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ROYAL COMMISSION
ON
HEALTH SERVICES



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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

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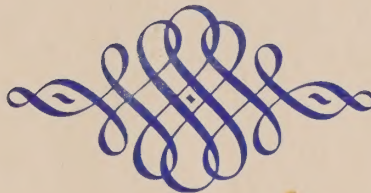
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearings
held in Toronto, Ontario,
on the 2nd day of June, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

Mr. M. WALLACE McCUTCHEON, Q.C.

Prof. O.J. FIRESTONE

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COMMISSION COUNSEL:

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COMMISSION SECRETARY:



12483

Toronto, Ontario,
Saturday, 2nd June, 1962.

--- On commencing at 9.00 a.m.

THE SECRETARY: Mr. Chairman, the first submission this morning is that of the Ontario Federation of Labour and will be known as Exhibit No. 374. Mr. Archer will present the members of his delegation to the Commission.

--- EXHIBIT NO. 374: Submission of the Ontario Federation of Labour.

SUBMISSION OF THE ONTARIO FEDERATION
OF LABOUR.

Appearances: D.F. Hamilton
W. Boothroyd
J.H. Craigs
Dave Archer
Ted Goldberg
Gordon Milling

MR. ARCHER: Mr. Chairman, I have a very short statement to read. I am not going to read the brief. I would first like to introduce the persons I have with me, who will answer any questions you may have.

Gordon Milling, Research Director of the Steelworkers, until very recently, Research Director of the Ontario Federation of Labour; Ted Goldberg, Research Director of the Steelworkers, who has specialized in health plans and health services; Doug Hamilton, the Secretary-Treasurer of the Ontario Federation of Labour, who has been sort of Chairman of this Committee in gathering it all together; Bob Craigs, the Research



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Archer

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Director of the Steelworkers; and Bill Boothroyd of the International Association of Machinists, and a Vice-President of the Federation of Labour; and myself as President.

Mr. Chairman and members of the Commission:

The Ontario Federation of Labour is the provincial arm of the Canadian Labour Congress in the Province of Ontario. Therefore, much of what is in our brief is the same as that presented to your Commission by the Canadian Labour Congress on May 25th. Your Commission have had our submission in your hands for some time now and no doubt have already studied it. For these reasons we will not take up the time of your Commission to read the brief.

However, there are two main points that we would like to emphasize that were not dealt with in detail in the Canadian Labour Congress submission. These are the gaps in existing plans, and the developments surrounding group practice in Ontario. The gaps in existing plans are demonstrated in Appendix "A" and "B" in our brief. In this regard we would like to make a slight correction in the third line in Appendix "B". Would you please change the year 1959-60 to read 1960-61.

In regard to group practice, we have just recently been given a report prepared for the Toronto & District Labour Council by Dr. John H.F. Hastings, M.D., D.P.H. Mr. Chairman, as you know, we are contemplating developing a health centre in Toronto,

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Archer

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and this report is still in limited supply and has not yet been made public. You are the first group to get it.

This report was prepared in conjunction with a study being conducted by a special committee of the Toronto & District Labour Council. We trust that this report will be of interest and assistance.

The highlights of our submission are to be found in the summary on pages 1, 2 and 3. As we stated previously, these are, in the main, the same as those in the Canadian Labour Congress brief.

If there is any further information which our Federation can supply, please let us know and we will do our utmost to get it for you.

I thank you very much for your attention, Mr. Chairman and members, and if there is anything my fellow members can add, they will be glad to do so.

THE CHAIRMAN: Thank you very much, Mr. Archer. We are pleased to have this report of Dr. Hastings, and some of the matters that I was going to discuss with you this morning may well be covered in here, because this matter of group practice is one with which we are, I think, particularly concerned.

Mr. Goldberg, in connection with Appendix "B"; this does not affect the content of the appendix, but there is continuous reference made to the Travellers' Plan. Is that an error, and it should be the Prudential one?

MR. GOLDBERG: No.

THE CHAIRMAN: What is the significance



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of using that?

MR. GOLDBERG: The Travellers' is the Travellers' Insurance Company's plan, which is, in effect, one of the companies being studied in the Hamilton study.

THE CHAIRMAN: I will just go to the first paragraph. This is what is bothering me. "Of this total, 482 families were those whose main breadwinner was employed at the Hamilton Works of the Steel Company of Canada, and who were covered for health insurance benefits through the collective bargaining agreement between the Company and the United Steelworkers of America. The plan covering these people was underwritten by the Prudential Life Assurance Company of America."

MR. GOLDBERG: I am sorry. It should be Travellers' Life Insurance.

THE CHAIRMAN: We can just make that change, then?

MR. GOLDBERG: Yes, I am sorry. Does the rest of it follow through with Travellers'?

THE CHAIRMAN: I think so. Everything else falls into place once that correction is made.

MR. GOLDBERG: Yes.

THE CHAIRMAN: Now then, this Appendix "B", is this the total survey, or a summary of it?

MR. GOLDBERG: This is a summary of the survey. The total report is now being prepared, and it will be made available to the Commission when it is completed.

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Goldberg

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THE CHAIRMAN: Because it is a most interesting survey from the figures, inasmuch as it does not show a definite pattern in some respects, and in other areas it does. When the complete survey is ready, if we could have it, because, as I say, this does give figures, and in an area where few figures are available.

MR. GOLDBERG: Well, what we tried to do, Mr. Chairman, was to get the information to the Commission for your use, even though the total report was not available as yet, but it will be available shortly, and we will give it to you.

THE CHAIRMAN: As you say, Dr. Hastings has looked into this idea of group practice, although initially I think you are talking of a development here in Toronto. Is that something like the Sault Ste. Marie one?

MR. GOLDBERG: Well, there are certain differences, Mr. Chairman. The development in Toronto is the result of joint action by some 55 unions, national and international unions, who have come together to organize a Committee which is called the Toronto Labour Health Centre Organizing Committee, which has undertaken the responsibility of looking into the possibility of developing a group practice, comprehensive medical care program in the Toronto area. This is so far as we know.

THE CHAIRMAN: Are you looking for something like H.I.P. in New York, or something different?

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Goldberg

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11 THE CHAIRMAN: In this matter of group
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17 We are thinking of it on another basis
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19 of using the idea out in the remote areas, having a
20 group not necessarily living at the one central spot,
21 but dispersed over an area, which would provide a
22 reasonable measure of specialist services in the various
23 specialties for an area, say, a hundred miles square,
24 or something.

25 Have you had a chance to do any
26 thinking in that respect of group practice?

27 MR. GOLDBERG: Yes, I think the possibi-
28 lities of group practice are probably as great in rural
29 Canada as they are for the urban sections, and I would
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THE CHAIRMAN: Yes, that is Dr. Eccleston's. Mr. McCutcheon, Dr. Van Wart and I had the pleasure of meeting with Dr. Eccleston back in March.

MR. GOLDBERG: I think that here are the benefits of group practice being made available to a fairly rural area in the United States. Our thinking along these lines is that what we would like to see with the development of group practice is that even the doctors serving the remote areas would have a very direct connection with group practices existing in the urban areas, so that the population in the rural areas could be organizationally served by the whole group. Doctors could go up to the remote areas, specialists and so forth, or else the patients could be transferred into the group practice group.

THE CHAIRMAN: It is a matter of developing transportation?

MR. GOLDBERG: Organizational connection.

THE CHAIRMAN: Organized transportation?

MR. GOLDBERG: Yes, well, besides the transportation we think it is necessary to have an organizational set-up where these people are not isolated, but part of a larger group.

THE CHAIRMAN: You see, we may see this regardless of what overall method may be employed to provide services to the people; I mean, apart from how it is paid for, you still have to figure out a way of making it available. I am trying to equalize it in some measure. We cannot expect to have equality to a metropolitan area in a remote area. I mean, equality

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B/BL/hm

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THE CHAIRMAN: I don't suppose Dr. Hastings had that in mind in the work he has done.

MR. GOLDBERG: No. His report deals with the situation in Toronto.

THE CHAIRMAN: But if from the thought that has been given up to this point you might care to develop a little further that Rip Van Winkle deal, we would be very glad to have your views in that regard.

MR. GOLDBERG: We would be very glad to supply it.

THE CHAIRMAN: As you mention in almost the last paragraph there, "we have attempted to put as briefly and concisely as possible our position on the matters before you, and we trust that this will be of assistance." I think that is exactly what you have done in your brief. It is to the concise point and again accepting the basic views put forward by Mr. Jodoin and yourself the other day.

MR. GOLDBERG: Yes.

THE CHAIRMAN: So to that extent there is no necessity of just reviewing the things we discussed the other morning.

COMMISSIONER McCUTCHEON: Just one or two points, Mr. Chairman. As you said, this ~~brief~~ is substantially along the same lines of the one that was presented the other morning when Mr. Jodoin and Mr. Goldberg were present.

If I might jump around a little bit, Mr. Goldberg, on page 21, paragraph 59, you have referred to the employers' contribution and you refer to the fact

12491

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Goldberg

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5 for a certain health service provided to the employees
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7 50-50 basis or some other basis. Now, you say:

8 "We believe that this arrangement
9 "should be preserved. We suggest that
10 "consideration be given to an earmarked
11 "employer contribution on behalf of
12 "employees to replace the current
13 "employer contributions to private
14 "plans."

15 Earlier you have said in effect that
16 this very comprehensive plan that you are recommending
17 should be financed out of the general tax revenue. Now,
18 first, specifically how do you see this plan being
19 financed?

20 MR. GOLDBERG: May I ask Mr. Hamilton
21 to answer this.

22 COMMISSIONER McCUTCHEON: Yes.

23 MR. HAMILTON: Well, Mr. McCutcheon,
24 I think this was explained pretty thoroughly the other
25 day.

26 COMMISSIONER McCUTCHEON: Yes, but this
27 point I don't think was raised the other day. I would
28 just like you to tell me how you would expect it to be
29 financed.

30 MR. HAMILTON: As far as the sharing ---

COMMISSIONER McCUTCHEON: Before we
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TORONTO, ONTARIO

Hamilton

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MR. HAMILTON: It could be financed
by the Federal Government by various means.

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COMMISSIONER McCUTCHEON: What means
do you suggest? Increase in sales tax?

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MR. HAMILTON: No, we are opposed to
increase in sales tax.

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COMMISSIONER McCUTCHEON: Corporation
tax?

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MR. HAMILTON: Yes, corporation taxes
and income tax would be two revenue-producing aspects
of it.

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COMMISSIONER McCUTCHEON: You would
go along with my suggestion that that would inevitably
mean an increase in taxes?

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MR. HAMILTON: It might very well.

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COMMISSIONER McCUTCHEON: Can you
suggest any way it wouldn't?

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MR. HAMILTON: Well, the plan wouldn't
cost any more than it is going to cost now.

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COMMISSIONER McCUTCHEON: It is going
to be paid for by government. I won't get into a
discussion whether it will cost the country overall
more. It is going to come out of government.

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MR. HAMILTON: That is correct.

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COMMISSIONER McCUTCHEON: And that
means increased taxes?

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MR. HAMILTON: Yes.

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COMMISSIONER McCUTCHEON: And your
suggestion is income taxes, personal income taxes and
corporation tax?

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MR. HAMILTON: It could be financed

by the Federal Government by various means.

COMMISSIONER McCUTCHEN: What means

do you suggest? Increase in sales tax?

MR. HAMILTON: No, we are opposed to

increase in sales tax.

COMMISSIONER McCUTCHEN: Corporation

and income tax would be two revenue-producing aspects

COMMISSIONER McCUTCHEN: You would

go along with my suggestion that that would inevitably

mean an increase in taxes?

MR. HAMILTON: It might very well.

COMMISSIONER McCUTCHEN: Can you

suggest any way it wouldn't?

MR. HAMILTON: Well, the plan wouldn't

cost any more than it is going to cost now.

COMMISSIONER McCUTCHEN: It is going

to be paid for by government. I won't get into a

discussion whether it will cost the country overall

more, it is going to come out of government.

MR. HAMILTON: That is correct.

means increased taxes?

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4 MR. HAMILTON: Yes.

5 COMMISSIONER McCUTCHEON: Well, we
6 have an employer -- I know of several who are at the
7 present time paying the entire premium for employees
8 for what I consider a very comprehensive plan. I notice
9 they are not included in your survey here. Are you
10 suggesting, in addition to paying an increased corpora-
11 tion tax, that employer should also continue to pay for
12 the employees?

13 MR. HAMILTON: Well, when we negotiated
14 for the benefits of some of the plans, some were on a
15 50-50 basis, some were paid entirely by employers, some
16 were paid entirely by employees, and we say if this is
17 going to be changed we should have a change in this wage
18 packet in any form.

19 COMMISSIONER McCUTCHEON: Are you going
20 to say, as a matter of law, a generous employer must have
21 his corporation taxes raised in addition to making a
22 special payment?

23 MR. HAMILTON: Well, it doesn't always
24 follow he is a generous employer because he is paying
25 the full cost. It is a matter of negotiations whether
26 he is paying the full cost. Some of the generous employers
27 by your standards may not be paying anything but be
28 paying better wages.

29 COMMISSIONER McCUTCHEON: I suggest that
30 it is usually the ones who are paying better wages who
31 pay the contributions, but I won't go into that.

32 Are you saying any more than that you
33 are going to continue to bargain with the employer and you

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start to bargain on that basis?

MR. HAMILTON: I think our experience under the introduction of the hospital plan is the thing we want and try to cure and try to recover, and we want to recover through negotiations or some other way this portion of our wage bracket that will be set aside.

MR. ARCHER: Basically we are saying that the health of our membership shouldn't depend on the generosity or lack of it of the employer.

COMMISSIONER McCUTCHEON: I think you are saying more than that; you are saying, as I read this, that by law the employer is going to continue to pay this contribution and taxes. That is what the Saskatchewan Act purports to do.

MR. ARCHER: Everybody is going to pay higher taxes and he is going to pay the higher taxes everybody else is and he isn't going to be any worse off than he is now.

COMMISSIONER McCUTCHEON: Oh, really, Mr. Archer, he is going to be worse off because he is paying for the benefits of groups that haven't had the benefits.

MR. ARCHER: The relative position is going to remain the same.

MR. HAMILTON: I think what Mr. McCutcheon is saying is isolating one package, and this we can't do.

THE CHAIRMAN: Are you saying that it should be incorporated in the law or not?

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THE CHAIRMAN: Are you saying that it

should be incorporated in the law or not?

MR. HAMILTON: We are saying that it



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should be incorporated in the law and should be recoverable

THE CHAIRMAN: You want the Saskatchewan pattern?

MR. HAMILTON: Yes.

COMMISSIONER McCUTCHEON: You want something better than the Saskatchewan one?

MR. HAMILTON: Yes.

THE CHAIRMAN: In effect, any experience in this type of negotiation in Saskatchewan is as a result of the statute?

MR. HAMILTON: I am not familiar with the Saskatchewan negotiations.

COMMISSIONER McCUTCHEON: You say at the foot of page 6, paragraph 18:

"The fact that Canada is one of the

"very few remaining economically

"developed countries that has yet to

"establish such a program makes this

"need all the more obvious."

Do I take it that such a program is the program you have recommended in paragraph 14?

MR. ARCHER: We are talking about a national health plan of some kind and we would prefer the one we have recommended, but programs of some form or another are established in what we call the economically developed countries of the world, perhaps outside of the United States.

COMMISSIONER McCUTCHEON: Do you accept my statement that there is no country in the western world that has a plan of the kind you are recommending?



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3 I don't like the inference that Canada is a second-rate
4 country.

5 MR. ARCHER: I wouldn't quarrel with
6 that statement.

7 MR. GOLDBERG: I would certainly say
8 that there is no country that I know of that has a
9 program identical with what we are suggesting.

10 COMMISSIONER McCUTCHEON: Or as
11 comprehensive.

12 MR. GOLDBERG: They all have approached
13 the development of their programs from their own
14 historical developments and their own points of view.
15 What we are suggesting is that Canada should also develop
16 its own national health program, and we are suggesting
17 along the lines we have outlined on page 5. This we
18 think is appropriate for Canada.

19 COMMISSIONER McCUTCHEON: All you are
20 saying is that Canada should develop a national health
21 program.

22 MR. GOLDBERG: Yes.

23 COMMISSIONER McCUTCHEON: You are not
24 implying that there is any country in the western world
25 that has developed a comprehensive program to be paid
26 for in the way you recommend, with no co-insurance
27 payments, no payments on time of receipt of service,
28 and so on.

29 MR. GOLDBERG: I quite agree, there
30 is no program identical to the one we are suggesting,
yes. I am not familiar enough with the others in the
rest of the world to say; I am not familiar, for example,

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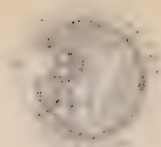
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4 with the Israeli program.

5 COMMISSIONER McCUTCHEON: Let's take
6 the Scandinavian countries, the United Kingdom and
7 Australia.

8 MR. GOLDBERG: Each of these programs
9 has differences to the one we are recommending here,
10 yes. Some are financed differently and some are financed
11 similar to what we are suggesting but they will have
12 differences. Some will be comprehensive but will be
13 financed differently. We are suggesting a program to
14 include these conditions that we think will be best
15 for Canada.

16 THE CHAIRMAN: Mr. Goldberg, isn't
17 this what you have done, and I don't say this critically,
18 you have eliminated -- in paragraph 14 you have built
19 up a program here and you have eliminated from it any
20 element of all these other national programs you don't
21 like?

22 MR. GOLDBERG: Quite true. If you are
23 suggesting we have recommended a program which includes
24 all the best of the other programs, we would agree with
25 you.
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THE CHAIRMAN: You mean the best,
you mean it will be paid wholly by taxes?

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MR. GOLDBERG: The best from our point
of view.

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THE CHAIRMAN: Without deterrents,
without means tests, without anything?

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MR. GOLDBERG: That is right, and we
are expecting that the program that will be developed in
Canada will lead the rest of the world in terms of
health programs.

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COMMISSIONER McCUTCHEON: That is
where you start bargaining.

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MR. ARCHER: Those are our demands.

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MR. HAMILTON: I think the point is
well made that we should certainly benefit by the experience
of other countries in this group practice and we are
behind at the moment. This is the ideal situation if
you want to buy it that way, but we should certainly
benefit by the experience in the other countries.

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THE CHAIRMAN: That is the very thing,
but you have eliminated the experience in Australia with
the drugs.

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COMMISSIONER McCUTCHEON: Experience
in the U.K. with drugs.

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THE CHAIRMAN: Particularly in Australia
with the drugs, because the thing went --- made the com-
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MR. GOLDBERG: I am not just sure of
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instance, that the co-insurance charge that covers for drugs was introduced simply as a means for increasing revenue and not because it was a way of cutting down the use of drugs. Now, the reports I have seen about it --

THE CHAIRMAN: You do not want revenue collected that way?

MR. GOLDBERG: We are quite frank about how we want the revenue supplied, it is not through co-insurance or out of pocket expenses.

THE CHAIRMAN: Or any provincial contribution?

MR. GOLDBERG: I do not think we say that.

THE CHAIRMAN: From personal income tax and corporation income tax.

MR. ARCHER: We have not ruled out provincial contributions anywhere in the brief, I do not think.

THE CHAIRMAN: I was trying to find any reference where we might be able to say you favoured it, because there is not a word in the brief that I can see about any provincial contribution.

MR. GOLDBERG: I do not think our delegation really is able to discuss the constitutional problems involved.

THE CHAIRMAN: I am not talking about constitutions, I am talking about finding of the wherewithal to pay for it.

MR. GOLDBERG: In terms of policy.

THE CHAIRMAN: In terms of cash.

MR. GOLDBERG: Well, we are not prepared

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Goldberg 12501

to discuss the constitutional setup.

THE CHAIRMAN: It is interesting in your submission this morning that you want all this money to come from Ottawa.

MR. GOLDBERG: I do not think so.

MR. ARCHER: We are worried, because of the difference ----

THE CHAIRMAN: You say from personal income tax and corporation tax, can that mean anything else but from Ottawa?

MR. ARCHER: That was in answer to a question. I think something has to be worked out with the provinces, but the provinces are so different that it is very difficult to say what that arrangement should be. Ontario is a very rich province, I do not know if the Federal Government would have the same relationship with it as it might have with Nova Scotia. We happen to represent the richest province, but we would not like to lay down a policy that might do more damage to a national health plan as such because some other poorer provinces --- I better not say that or I will get into trouble ---- some other province not as rich as Ontario is unable to meet the requirements.

COMMISSIONER McCUTCHEON: Who do you envisage operating this plan?

MR. GOLDBERG: Well, I would think, Mr. Chairman, and subject to the comments of my colleagues, that the plan would be under the administration of the Department of Health.

COMMISSIONER McCUTCHEON: The Federal



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MR. GOLDBERG: Here again it is a matter of the question of federalism. I would think that the pattern probably would be similar to that of the Hospital Plan where it would be a grants-in-aid program established under Federal enabling legislation but carried on by the Province, and therefore, I would imagine the program would be carried out under the Provincial Departments of Health based on certain minimum requirements established through enabling legislation.

COMMISSIONER McCUTCHEON: In those circumstances you would envisage a contribution from the Provincial Treasury?

MR. GOLDBERG: I would.

MR. ARCHER: I think we can say so.

THE CHAIRMAN: In that context can you see anything of a uniform plan across the country? You say certain minimums, but anything uniform?

MR. GOLDBERG: Minimally uniform. About that I think there would be quite a wide area for development experimentally.

THE CHAIRMAN: I am speaking now of principle.

MR. GOLDBERG: In principle I think it would be uniform across the country.

THE CHAIRMAN: We talk about other countries, we have to deal with Canada as it is and in the 1960's. Do you think there is any use letting the idea be disseminated that it is possible for Ottawa to impose conditions on the provinces of Canada and say, "This is



Colombia 1950

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THE CHAIRMAN: We talk about other

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what you must do and you must do it our way".

MR. GOLDBERG: Simply speaking in terms of a Hospital Act, I would think conditions imposed there provide for certain minimum standards to be adhered to by other provinces in the country and I would think---

COMMISSIONER McCUTCHEON: What are the minimum standards in the Hospital Act? There are no standards of quality, no standards as to how the provinces are to collect the money, there is nothing to say you must get all your drugs, because some provinces give all the drugs and some do not.

MR. GOLDBERG: Am I wrong in thinking or recalling that the legislation passed by Ottawa provides for certain requirements that must be adhered to by each of the provinces in order to participate in this grant-in-aid program? I recall, and I do not have the legislation in front of me, but I recall there is a list of things to be provided in the provincial legislation in order for it to qualify for this. This is what I would consider minimum regulations to be applied right across the country. If you wish, I would be more than happy to do this for you if you would like me to prepare for the Commission my interpretation of the enabling legislation for the Hospital Act, I would do it, but I am sure your staff probably will or has done that.

COMMISSIONER McCUTCHEON: I do not think that is necessary, but I agree with you.

THE CHAIRMAN: The Act says so.

COMMISSIONER McCUTCHEON: The Act says certain things but when you come to analyze them or come

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to see how the Act is applied in various provinces, you will see some very great variations fundamentally. Diagnostic services is a very broad term, the standard ward care is a broad term and those are the two fundamental standards. In other words, can you see --- I am repeating what the Chairman asked --- there are no standards of quality laid down and you have emphasized quality right through this and the nursing care depends upon the province or the administrator of the hospital or a variety of things. Now, how far do you see the Federal Government imposing conditions on the Province of Quebec, just to get an example, under your scheme?

MR. GOLDBERG: We think it is quite feasible, we have not worked this out in detail, quite admittedly, to establish through Federal enabling legislation certain standards to be applied in the provision of medical care services.

THE CHAIRMAN: I am going to move into the very thing that you seem to attach fairly great importance to, no co-insurance, no deterrent, no premium.

MR. GOLDBERG: Yes.

THE CHAIRMAN: Do you think that Ottawa will be able to say to every province in Canada, "You must not collect a half cent from so and so". Do you they would go to the Province of Alberta where they are collecting \$1.00 a day or to British Columbia where they are collecting \$2.00 a day and tell them they cannot do it?

COMMISSIONER McCUTCHEON: Or Ontario collecting a sales tax.

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COMMISSIONER McCUTCHEN: Or Ontario

collecting a sales tax.



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MR. GOLDBERG: I would not want to comment on the political feasibility of these things.

THE CHAIRMAN: We have to give consideration to things that will be feasible.

MR. GOLDBERG: I would suggest this enabling legislation might very well provide that the provinces should follow certain standards which may include not charging deterrent fees and so on in order to insure high quality services which we advocate.

COMMISSIONER McCUTCHEON: You do contemplate a provincial contribution?

MR. GOLDBERG: I would think so, yes.

COMMISSIONER McCUTCHEON: How would you suggest the province is to get the money to pay? Certainly no room in Ontario for any more disbursements without more taxes; should we make the sales tax 5% in Ontario?

MR. GOLDBERG: I would not be able to react to your question specifically, but I will certainly think about it.

COMMISSIONER McCUTCHEON: I would like your views as to how the provinces are going to raise their share of the money specifically. I would like your views as to what you think their share should be.

THE CHAIRMAN: And I think we must ask you to also consider whether the provinces must be restricted in some form of uniformity in raising the money, because -- that is restricted as against collecting the premium, restricted as against having a per diem charge or a first charge for drugs, all these things which you say cannot be.



Archer 12506

COMMISSIONER McCUTCHEON: As a matter of information, Mr. Archer, Appendix A, starting on Page 3 of Appendix A you have a list. Is this simply a list of the employers who were surveyed by Mercer and whose results are analyzed on Pages 1 and 2?

MR. ARCHER : That is right, sir.

COMMISSIONER McCUTCHEON: Was there any pattern to selecting the particular employers that you selected? For instance, the list is spread across the province, but I see you only have -- leaving out the Federal Government employees and public service ---

MR. HAMILTON: Mr. Craigs was with the civil service ----

MR. CRAIGS: This was done on a basis of two points; first was we were trying to get a cross-section of the province. You will notice that they are fairly well spaced out. Secondly, part of the people that were surveyed was dictated by the fact that in these centres were a reasonably large number of civil servants already working in the area, most of them in the Department of Health, Ontario hospitals, and the idea was to relate the status, the medical status of the public employees of the Province of Ontario with industrial and commercial enterprises in the area.

COMMISSIONER McCUTCHEON: That is the purpose of the survey, to make a comparison between the industrial employee benefits and the benefits of the Federal Civil Service?

MR. HAMILTON: No, the Provincial Civil Servants.



8 of Appendix A you have a list. Is this simply a list
of the employers who were surveyed by Mercer and whose
results are analyzed on Pages 1 and 2?

COMMISSIONER MONTGOMERY: Was there any

pattern to selecting the particular employers that you
selected? For instance, the list is spread across the
provinces, but I see you only have -- leaving out the
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MR. HAMILTON: Mr. Craig was with the

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MR. CRAIG: This was done on a basis
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ment of Health, Ontario hospitals, and the idea was to
relate the status, the medical status of the public
employees of the Province of Ontario with industrial and
commercial enterprises in the area.

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industrial employee benefits and the benefits of the
Federal Civil Service?

services.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Craigs 12507

COMMISSIONER McCUTCHEON: Why is Sunnybrook Hospital in here?

MR. CRAIGS: The reason that was put in, it is one of the few areas in Ontario in which there was a hospital of comparable size and of comparable character to an Ontario hospital.

COMMISSIONER McCUTCHEON: Well then, what other criteria were made in selecting --- for instance, you only have two Toronto firms, one a retailer and the other is a relatively small manufacturer and you have no firms from Hamilton. Now, those are the two large industrial areas. You go to Windsor, you have the University, you have the City of Windsor, the City of Chatham and a small dairy company, what was the basis of selecting these industrial firms, that is what I do not understand. I can think of a number that could be more representative.

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proof hospital in here?

MR. GEAIS: The reason that was put in

it is one of the few areas in Ontario in which there was
a hospital of comparable size and of comparable character
to an Ontario hospital.

COMMISSIONER McCUTCHON: Well then,

what other criteria were made in selecting --- for instance,

you only have two Toronto firms, one a retailer and the
other is a relatively small manufacturer and you have no
firms from Hamilton. Now, those are the two large

industrial areas. You go to Windsor, you have the

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Chatham and a small dairy company, what was the basis of

selecting these industrial firms, that is what I do not

understand. I can think of a number that could be more

representative.



D/MR/hm

Hamilton

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4 MR. HAMILTON: Mr. McCutcheon, in order
5 that we put this in its proper prospective for the
6 Commission -- this is not a job that we did, the Ontario
7 Federation of Labour did not do this job. Mercer did
8 it for the Civil Service. I agree it is spotty in all
9 of the things you point out but all we are simply saying
10 to the Commission that this is a survey that is available.
11 It has indicated, to some degree, whatever the weight
12 the Commission wants to put on it, the gaps in existing
13 plans.

14 COMMISSIONER McCUTCHEON: How much
15 weight do you put on it?

16 MR. HAMILTON: Considerable, because
17 I think we wouldn't have used it -- if we didn't think
18 this was showing a pattern which we do find in industry
19 in Ontario, -- we would not have used it. We could have
20 prepared a similar one that would ---

21 COMMISSIONER McCUTCHEON: Show quite
22 a different pattern?

23 MR. HAMILTON: That is right, but I
24 think that this is a pattern that is in Ontario that
25 we find and to that degree we simply say the Commission
26 put as much weight on this as they think it is advisable
27 to do so. It has been prepared for us, it was not
28 prepared by us and we are not prepared to defend it in
29 the context that you want us to but simply as evidence
30 of what is existing.

MR. ARCHER: Mr. McCutcheon, isn't it
a good cross section? I am just looking at it. Isn't
it a good cross section of different kinds of industry



Archer

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in Ontario? Big ones, little ones?

COMMISSIONER McCUTCHEON: I don't see the big ones.

MR. ARCHER: What about Canadian Locomotive, Silverwood's Dairy, Kellogg's, surely the biggest in the world I suppose. Great Lakes Paper Company.

THE CHAIRMAN: 600 employees in Ontario.

MR. ARCHER: And some smaller ones. Some newspapers. It seems to me, I don't know anything about it, the Mercer Company has tried to get a Gallup Poll of the industry.

COMMISSIONER McCUTCHEON: I don't know why some of the steel companies aren't on here. I can make a number of criticisms.

MR. ARCHER: I am sure you could.

COMMISSIONER McCUTCHEON: There seems to be whole blocks of industry that are omitted. I will say no more. There is no point in pursuing it any further.

MR. HAMILTON: All we are saying is there are great gaps in existing plans. We think this points it up for you.

COMMISSIONER BALTZAN: Gentlemen, I wonder if you could give me an explanation. In the first place, I draw your attention to page 3 and the three paragraphs that follow. Have you got that page 3? Paragraphs 9, 10 and 11. I am very pleased that you draw attention to this particular matter. Am I to conclude, as the result of that, that what eventually



Archer

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3 becomes a medical problem has, as you say, its roots
4 in other areas as the result of which, and this has
5 been bothering us in talking to many people everywhere,
6 as the result of this the remedies to this that you
7 mentioned are not exactly medical but they are actually
8 what you call here economic so someplace in between,
9 you don't know where, the economic feature enters as
10 the cause and medical attention enters in as the factor
11 producing the expense in relation to the total product.
Do I make myself clear?

12 MR. HAMILTON: Yes.

13 COMMISSIONER BALTZAN: This is what
14 I am to gather from that?

15 MR. HAMILTON: That is correct.

16 COMMISSIONER BALTZAN: What is not
17 originally medical eventually does become and then things
18 get mixed up somewhere.

19 MR. ARCHER: That is a fair statement
of our position.

20 COMMISSIONER BALTZAN: One other
21 thing. We had a considerable amount of similar
22 statements and this is the question of equitable distri-
23 bution of doctors and other personnel to sparsely
24 populated areas. We have heard that from x-ray
25 technicians, from laboratory technicians, as well as
26 other personnel. The difficulty appears there not from
entirely a financial need but shortage by incentive
27 because it is not attractive. You stress the financial
28 but as things are going the pattern does seem to be
29 changing considerably.
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4 Instead of, as we learned particularly
5 in the Prairies and Newfoundland, instead of forcing
6 these unwilling people to go to these areas, the need
7 is lessening for the urgency of them because of other
8 developments in relation to rapid transportation so that
9 perhaps would you agree with me it is not a question of
10 having to insist on trying to place some unwilling
11 people in these areas but as to try to obtain ways and
12 means of getting these people to the needed ones, the
13 areas for immediate medical treatment.

14 Would you insist or does the pattern
15 show that the original premise is you must place or
16 bring these services to this area or it could be either
17 economic other ways? It would be more suitable to see
18 that these people, to see means of getting the treatment
19 by rapid transportation.

20 MR. GOLDBERG: Some of the things you
21 are suggesting, Dr. Baltzan, obviously have to occur.
22 I cannot visualize a neuro-surgeon being in every
23 community across Canada.

24 COMMISSIONER BALTZAN: I am not talking
25 about the high specialty.

26 MR. GOLDBERG: What we are suggesting,
27 I think, is that there has to be a better distribution
28 of medical personnel across the country. This is only
29 equitable and fair for the people in the country. One
30 of the techniques of attracting people to some of these
areas is a financial one. We think there are other
inducements also important that we have tried to indicate
in our presentation.



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in the Princes and Newfoundland, instead of forcing these unwilling people to go to these areas, the need is lessening for the urgency of them because of other developments in relation to rapid transportation so that perhaps would you agree with me it is not a question of having to insist on trying to place some unwilling people in these areas but as to try to obtain ways and means of getting these people to the needed ones, the areas for immediate medical treatment.

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Goldberg

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4 I think one thing that is keeping a
5 person from locating in a rural area is that he becomes
6 isolated, not only geographically, but professionally
7 and we think that as group practice development
8 spreads across the country where a person in a rural
9 area can be in integral part of a larger group practice,
10 then you are going to have people being established
in these rural areas.

11 What we would recommend is that the
12 report of the Commission include recommendations for
13 the furthering of group practice for the development
14 of this practice on a much larger scale than has been
up until now.

15 One other area, we agree there has
16 to be increased provision for bringing people from rural
17 places into urban places for higher quality medical care
18 and this would be just one other aspect which should be
organized. We would agree with that.

19 COMMISSIONER BALTZAN: I will leave it
20 at that. We can extend the discussion. It is worthwhile
21 to talk about it from every aspect. Now I do not want
22 to open up a big subject but it has come to me, after
23 listening so many times to the subject of means tests,
24 and I am going to put it to you very plainly and simply:
25 Is the objection to the idea; is a means test in itself
26 the objection or are the means by which the means test
27 is obtained objected to? Does that constitute the
objection?

28 MR. HAMILTON: I think the means test,
29 as far as we are concerned, is not administratively a
30



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COMMISSIONER BARTON: I will leave it at that. We can extend the discussion. It is worthwhile to talk about it from every aspect. Now I do not want to open up a big subject but it has come to me, after listening so many times to the subject of means tests, and I am going to put it to you very plainly and simply: is the objection to the means test in itself the objection or are the means by which the means test is obtained objected to? Does that constitute the objection?

MR. HAMILTON: I think the means test, as far as we are concerned, is not administratively a



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3 sound position and it is objectionable usually in its
4 application and as a pretty general principle in this
5 kind of scheme we are opposed to the means test.

6 COMMISSIONER BALTZAN: I accept that
7 very thoroughly but we had listened to the discussion
8 both pro and con and that came to me particularly,
9 perhaps to others, that somehow this should be eradicated.
10 I get the impression it is the means test itself was
11 perhaps, to a large extent unavoidable but the impression
12 on the objection seemed to be to the methodology, the
13 way of obtaining the means test. In some areas
14 we have heard that one has to go through all sorts of
15 things before that is established and it is that method
16 that was objectionable rather than the fact of obtaining
it.

17 MR. HAMILTON: I think as I say in its
18 administrative application it is undesirable.

19 COMMISSIONER BALTZAN: For that reason.

20 MR. HAMILTON: In its administrative
21 application it is generally undesirable.

22 MR. ARCHER: I suppose when you give
23 somebody their old age pension and tax it back from them
24 you are imposing a means test in a very, very vague
25 sense of the way but the administration of a means test,
26 as such, applied to an individual before he can receive
27 services is the thing to which we are opposed.

28 COMMISSIONER BALTZAN: The application
29 of it?

30 MR. ARCHER: The application of it;
applying any form of means test to the individual before

second position and it is objectionable usually in its application and as a merely general principle in this kind of where we are opposed to the means test.

COMMISSIONER BALTMAN: I accept that.

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COMMISSIONER BALTMAN: The application

MR. ARONER: The application of it:

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Archer

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3 he can receive service. Through taxing system or
4 other system he may well be -- I think methodology is
5 probably a good word.

6 COMMISSIONER BALTZAN: Actually and
7 finally in practice we sort of are all victims of the
8 same thing. As for instance, when we go to obtain credit
9 anywhere.

10 THE CHAIRMAN: Not you Doctor.

11 COMMISSIONER BALTZAN: There is a
12 form of a means test. Thank you very much.

13 THE CHAIRMAN: Thank you very much
14 gentlemen. This has been a most pleasant discussion
15 here this morning and you have made your position clear
16 and that is the purpose of these public hearings so that
17 the position of various parties having a vital interest
18 in this very important subject should be made known
19 and so the Commission may, when it settles down to a
20 discussion of principle, be fully aware of the various
21 viewpoints and what reasoning is behind it.

22 MR. ARCHER: Mr. Chairman, just before
23 we adjourn, if that is the word to use, Mr. Hamilton
24 had a matter brought to his attention yesterday that he
25 would like to place before this Commission if he may.
26 It will only take a minute. We would like you to hear
27 it.

28 MR. HAMILTON: I think it is -- Mr.
29 McCutcheon may disagree with my word, a broad application,
30 I think this application where we run into a strike
situation where we have people covered in group plans
by one means or another, either the employees in part are

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Archer

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4 paying premiums or in some cases the employer is paying
5 the whole premium but what happens generally is, as a
6 weapon against the strike, the employer immediately
7 cuts off the group plan and the employee is left, after
8 considerable years of paying into it, without any
9 coverage.

10 COMMISSIONER McCUTCHEON: Would you
11 substitute what happens in some cases instead of
12 generally?

13 MR. HAMILTON: All right, I will
14 qualify it Mr. McCutcheon. We had a specific one brought
15 to our attention just yesterday and I thought this would
16 point up our problem in this field.

17 One of the companies has taken the
18 position, just a few days ago, that they won't supply
19 the union with any information relative to the plan
20 about how the payments were made, who was making the
21 payment, and as the result they are just letting this
22 whole program lapse.

23 Now I can let you have the name of
24 the company. I can file it with you if you want to and
25 the circumstances surrounding this, but this is an
26 example of the kind of thing where private coverage gets
27 us into great difficulties in some of these situations
28 and we simply raise it here as another one of our
29 objections to private coverage in this field.

30 THE CHAIRMAN: Whether it should
necessarily -- I am not defending it or condemning it,
or whether there is a remedial situation within the
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the company. I can file it with you if you want to and

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private climate.



Archer

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4 MR. ARCHER: We don't know where it
5 is.

6 COMMISSIONER McCUTCHEON: The employees
7 having temporarily withdrawn their services, I have no
8 doubt the union can go to the private carrier and say ---

9 MR. ARCHER: We don't know who he is.

10 COMMISSIONER McCUTCHEON: --- whatever
11 it is, we will pay it.

12 MR. HAMILTON: This I understand the
13 union have agreed to. I think they agreed to go to the
14 private carrier and say to the private carrier we will
15 pay the full cost of this plan and the private carrier
16 said we have not any agreement with you. You cannot
17 pay this. This is with the company. Therefore we
18 cannot accept your payment on behalf of these people.
19 This shuts the door. This is our problem.

20 THE CHAIRMAN: This is perhaps another
21 item to bargain the next time.

22 MR. HAMILTON: Yes, but I do not think
23 we should be bargaining with this kind of coverage.

24 THE CHAIRMAN: This is one way. You
25 say you cannot see of any way but it would appear that
26 it would be a very easy paragraph to put in an agreement,
27 to me.

28 MR. HAMILTON: We think that the way
29 out is to have the kind of plan that is national in
30 its application so it can be taken out of this area of
labour-management conflict.



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out is to have the kind of plan that is national in
its application so it can be taken out of this area of



Archer

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AG/dpw

THE CHAIRMAN: The viewpoint of the others, and I am not putting it forward as a dogmatic viewpoint, is that, all right, because you have a finger that has got blood poisoning, or for some reason or other should be amputated, that you don't take off the whole arm. It may not be necessary, so others said, to go completely from one phase to another, that there may be ---

MR. ARCHER: This is one reason we think you should go part of the way anyway, Mr. Chairman.

THE CHAIRMAN: That is the problem that faces us, and that is why I think that submissions such as we have had from you here this morning are valuable, because we would be terribly uninformed if we only had one side of the picture.

MR. HAMILTON: And the other unfortunate part of this, this happens to be the Equitable Life Insurance Societies of the United States, where we are having our trouble with ---

THE CHAIRMAN: You see, you will appreciate that the statement you make now is completely irrelevant to anything that this Commission could possibly be concerned with.

MR. ARCHER: Why?

THE CHAIRMAN: You are talking about some American domination or something. That is the idea you just mentioned there?

MR. HAMILTON: I am simply saying that this is the trouble we run into, and at a time when the people need their medical coverage more possibly than

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others, and I am not putting it forward as a dogmatic viewpoint, is that, all right, because you have a finger that has got blood poisoning, or for some reason or other should be amputated, that you don't take off the whole arm. It may not be necessary, so others said, to go completely from one phase to another, that there may be ---

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idea you just mentioned there?

MR. HAMILTON: I am simply saying that

this is the trouble we run into, and at a time when the people need their medical coverage more possibly than



Hamilton

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they would under other circumstances.

THE CHAIRMAN: I have said at other times that we are here to hear everything that is relevant. We cannot become a place where political or other grievances can be aired. This is a thing where it may be hard to find a dividing line. The first part, I think, is quite all right. When you come to the second part, I think we are going over the line.

MR. HAMILTON: We will leave it with you, then.

MR. ARCHER: Thank you very much, Mr. Chairman.



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times that we are here to hear everything that is rele-

vant. We cannot become a place where political or

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MR. HAMILTON: We will leave it with

MR. ARCHER: Thank you very much, Mr.



12519

THE SECRETARY: The next submission is a private submission from Dr. C. Collins-Williams and will be known as Exhibit 375.

--- EXHIBIT NO. 375: Submission of Dr. C. Collins-Williams.

SUBMISSION OF DR. C. COLLINS-WILLIAMS

Appearance: Dr. C. Collins-Williams

THE CHAIRMAN: Dr. Williams, you have asked permission to appear here this morning in connection with a submission which was made a few days ago.

DR. COLLINS-WILLIAMS: I was asked to come, sir, because I have written a letter to you which you possibly have not received yet.

THE CHAIRMAN: I just received it this minute.

DR. COLLINS-WILLIAMS: There is one in the mail actually, a signed copy.

Mr. Chairman and Commissioners: I think possibly the most expeditious way of presenting this is to read the letter. It is regarding the brief presented by Mrs. Marguerite Miles, Jarvis Street, Toronto, on Wednesday, May 30th, 1962.

I feel that I should familiarize the Royal Commission on Health Services about certain inaccuracies in this brief, some of them absolute falsehoods. You will realize of course that the only information I have as to what was in Mrs. Miles' brief is what I have obtained from the three daily Toronto newspapers of Thursday, May 1st, 1962.

THE SECRETARY: The next submission

is a private submission from Dr. C. Collins-Williams and will be known as Exhibit 17b.

SUBMISSION OF DR. C. COLLINS-WILLIAMS

Apparatus: Dr. C. Collins-Williams

THE CHAIRMAN: Dr. Williams, you have asked permission to speak here this morning in connection with a submission which was made a few days ago.

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papers of Thursday, May 3rd, 1962.



Collins-Williams 12520

I first saw this boy in consultation at the Hospital for Sick Children as a private patient in October 1956 at which time he had very severe asthma. I started treatment in my office at that time and continued to look after him as a private patient both in hospital and in my office until the early part of 1957 when the mother announced that she would have to go on Welfare. I told her at that time that the boy was a very severe asthmatic and I thought that we should continue exactly as we had in the past, treating him as a private patient and I would take anything that Medical Welfare paid for his care as payment in full. This meant that Medical Welfare would pay part of my ordinary office fees and any hospitalization would not be paid for as far as my charges were concerned.

In spite of this arrangement whereby Mrs. Miles had to pay absolutely nothing for care which was private and just as conscientious as I could give to even the wealthiest patients, she states in her brief that the charge was \$500.00 per year for desensitization injections. (Globe and Mail, May 31st). Since my charge for all private patients in my office, regardless of income, is \$2.50 per visit for these injections and since the patients come once a week, even if they do not miss one injection in an entire year the entire cost is only \$130.00. There are no extras to this charge as the patient may be examined at any visits if necessary, medications may be prescribed, telephone calls between visits are not charged for and even the medication which is injected to treat the asthma is



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of income, \$2.50 per visit for these injections and since the patients come once a week, even if they do not miss one injection in an entire year the entire cost is only \$100.00. There are no extras to this charge as the patient may be examined at any visit if necessary, injections may be prescribed, telephone calls between visits are not charged for and even the medication which is injected to treat the asthma is



Collins-Williams

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1
2
3 included in this fee. Therefore her claim that the
4 injections cost \$500.00 a year is completely absurd.

5 In the Daily Star of the same date,
6 she is quoted as saying that soon after she went on
7 Welfare, there was a change in the Doctor's attitude
8 and that certainly he was "much nicer to me as a
9 private patient." This is an absolutely unfounded
10 statement. In the first place it was my idea that he
11 should continue to come to my office as a private
12 patient. I pointed out to her that we had an excellent
13 Allergy Clinic at the Hospital for Sick Children (of
14 which I am the Director), I mean of the Clinic, not of
15 the hospital, and treatment there was completely adequate.
16 However, since he was such a bad asthmatic and since I
17 knew him so well, I thought it best that I personally
18 should continue his treatment. This was a satisfactory
19 arrangement for Mrs. Miles at that time, and over a
20 year after she was on Welfare, she wrote me a letter
21 under date April 28th 1958, the last paragraph of which
22 read as follows:

23 "May I say Dr. Collins-Williams, from
24 the bottom of my heart, I am deeply
25 grateful to you for the very fine
26 medical attention that you have been
27 giving this child since you took him
28 over, it is wonderful indeed to place
29 my confidence in you and to know that
30 under you, Chris is getting the best
possible care. If ever prayers are
sent to Heaven for your continued good

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sent to Heaven for your continued good



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nature, health and longevity they
surely come from me. Thank you very
much."

This was signed "Marguerite Miles".

In October, 1961, Christopher Miles discontinued coming to the office and because I was concerned about this I wrote to Mrs. Miles on January 23rd, 1962, pointing out that he had not been in. She then brought him into the office and said that she was discouraged with his treatment (and I may point out that he is a very severe asthmatic who has certainly been very resistant to treatment) and that she wondered whether the injections should not be discontinued. I told her that I thought they should be continued but that maybe it would be more convenient for her to obtain them from a physician closer to home. She then gave me the name of Dr. L. Roy on Dunfield Avenue in Toronto, and I wrote to him giving him a summary of the case and also sent him the treatment extract so that he could continue the injections. This was with the hope that Mrs. Miles would not discontinue them just because she had to come a long way to obtain them. Yet she is quoted in the Toronto Star as saying that she switched to another doctor because she was dissatisfied with the boy's progress.

May I conclude by saying that I have always given this boy as conscientious care as I have given any other patient regardless of financial status. The mother and I have always been on good terms as far as I had known, and I thought that we parted friends

Collins-Williams

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Collins-Williams

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and that the transfer to another physician was entirely to make things easier for her. It is therefore very difficult to understand such a brief being presented to the Royal Commission on Health Services.

Again may I emphasize that my only knowledge of what Mrs. Miles' presentation was is what I have obtained from the newspapers and if any misquotations have been made I am not in a position to know.

Now that, Mr. Chairman, is the end of the letter. I have one more piece of information which I just acquired yesterday in reference to this case. This case is naturally very distressing to us, because I myself and those of us at the Hospital for Sick Children have spent a lot of time and effort on this boy. He has had 35 admissions to hospital since his birth, all for asthma, and the Accounting Department has made a breakdown of the hospital charges to see how difficult they were for her.

The total hospital bill for 35 admissions, not including his present admission which is his 36th, was \$2,895.32. This has been paid by various agencies, and the entire amount for the whole 35 admissions paid by Mrs. Miles has been \$5 and this, of course, makes one wonder why the fees charged in her brief are so exorbitant.

THE CHAIRMAN: Well, Dr. Collins-Williams, you asked for the opportunity to make this statement. We are pleased to receive it, because you are as much entitled to be here as was Mrs. Miles.

As I said to her at the time, this



and that the transfer to another physician was entirely to make things easier for her. It is therefore very difficult to understand such a brief being presented to the Royal Commission on Health Services. Again may I emphasize that my only

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Collins-Williams

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Commission is not constituted, nor in a position to decide individual cases of so-called injustices, or alleged injustices, but we are a public inquiry and the information comes before the Commission, and you had the opportunity to reply to it. Thank you very much.

DR. COLLINS-WILLIAMS: Thank you very much, sir.



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decide individual cases of so-called injustices, or
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THE SECRETARY: Mr. Chairman, the next submission is from Dr. M.A. Dreyfus, and will be known as Exhibit No. 376.

--- EXHIBIT NO. 376: Submission of Dr. M.A. Dreyfus.

SUBMISSION OF DR. M.A. DREYFUS

Appearance: Dr. M.A. Dreyfus

DR. DREYFUS: Mr. Chairman, Commissioners, and members of the Committee, ladies and gentlemen: I would like to introduce myself. I am a graduate from Paris, 1942, and I did practise in France for seven years, and I have been sent by the French Government to the United Nations Organization U.N.R.R.A. as a Medical and Public Health Officer, and I came to Canada in 1953, and since 1957 I am established as a paediatrician in Ottawa.

I am a little bit sorry for my accent.

THE CHAIRMAN: Dr. Dreyfus, would you please speak and read more slowly, so that the reporter may have an opportunity to record what you are saying.



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THE CHAIRMAN: Dr. Dreyfus, would you
please speak and read more slowly, so that the reporter
may have an opportunity to record what you are saying.



Dreyfus

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DR. DREYFUS: A recent survey has revealed that 50% of the active population of Canada receives benefits from health insurance for medical services. The existing plans of health insurance are complicated, subject to confusion and in great need of clarification if all parties concerned are to receive good treatment.

An examination of the various insurance plans shows that they contain so many conditions that a patient is faced with a real problem when he tries to understand the general as well as the specific clauses of his contract. Invariably he is left with the erroneous impression that his contract provides him with complete coverage for all medical services. This is evident when we consider the types of plan in operation.

The following is a broad classification of the types of plan available:

- 1) Various plans with monetary contributions at a premium, some with total reimbursement, others with partial reimbursement.
- 2) Plans with limited coverage.
- 3) Plans limited to hospital benefits.
- 4) Plans with special clauses where benefits can be cancelled.
- 5) Plans whereby no provision is made for drugs, except for Civil Service personnel.

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Dreyfus

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clearly inadequate as far as coverage is concerned for each one is lacking in some respect or other, and therefore unsatisfactory from the insured's point of view.

From the doctor's standpoint, present plans appear objectionable for the following reasons:

- 1) That the medical profession could be charged with creating "a political action fund" to fight attempts to establish a medical services plan covering everyone in Canada.
- 2) In a crisis Canada could adopt a plan identical to the one in Great Britain.
- 3) The interference of the Federal and Provincial Governments to an extent that would jeopardize the professional relationship of patient and doctor.
- 4) Time wasted in completing reports, detailed description of surgical procedures and treatments, visits at the hospital, at the office and house calls.
- 5) A medical scheme that is introduced with excessive haste and without due regard to all the interest of those concerned, such as is witnessed in Saskatchewan cannot but lead to a fiasco.

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Dreyfus

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A plan fully acceptable to all parties and capable of implementation in all provinces would have to be simple, it should leave to the Federal and Provincial Governments the authority to make regulations but would be administered by private insurance companies.

Ideal Insurance Scheme

It is essential that this plan be actuarially sound.

Primary Objective:

- 1) Freedom of choice of doctor
- 2) Complete coverage
- 3) Partial contribution by patient (except for the indigent).

Secondary Objective:

- 1) Uniformity of report forms
- 2) Eliminating reports (in extenso) for the sole purpose of reimbursement to patient
- 3) Compulsory assignment.

Introduction to a better Health Insurance Scheme

General consideration: It appears that the majority of Canadians would support an all-inclusive contributory health scheme for everyone through private enterprise; what is needed is a degree of government assistance thereby helping those who cannot help themselves.

An analysis of the present health plans demonstrates that there is room for improvement, therefore let us consider some modifications and components of a simple plan acceptable to all parties concerned.



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Dreyfus

12529

It can be stated here that the medical profession has expressed the views propounded in other provinces than British Columbia, quite consistently retreating in no degree from their advocacy of continuance of the voluntary system for the prepayment of medical care on an expanded basis.

The Plan

It is essential that this plan be actuarially sound.

Primary Objective:

Freedom of choice of doctor.

Complete coverage.

Patient's contribution for medical services & drugs 20%.

Payment of fees made direct to the doctor except when Patient in Hospital Benefits identical.

For patients treated at home or at the office 80% reimbursement, starting with the first visit or the first house call.

For patients treated at the hospital selective medical benefits.

For the indigent, to the present Ontario Welfare plan could be added on a partial basis, reimbursement for treatment in hospital and drugs. The 20% contribution by the patient could be covered as it is done in some countries by mutual insurance



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Dreyfus

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companies.

Patient to receive weekly indemnity
one week after onset of illness.

Conclusion: It is obvious that the
doctor's role in this health insurance plan is limited
to the medical reports in connection with the absence
and return to duty, a group of doctors can be called
upon as consultants with regards to schedule of fees.

The financing of such a plan can be
implemented by the Federal or Provincial Government or
on a voluntary system for the prepayment of medical
care on an expanded basis through private enterprise.

THE CHAIRMAN: Thank you very much, Dr.
Dreyfus.

On page 2, where you deal with the
secondary objective, No. 3, compulsory assignment; I
haven't been able to figure out what you mean there.

DR. DREYFUS: Yes, it is something
very special. For the time being, when you sign an
insurance form, if he is not paid his fees in certain
cases, he has a bill to pay or his garage bill and he
keeps the money for that.

THE CHAIRMAN: It is to see that the
monies reach the doctor and are not pocketed by the
patient?

DR. DREYFUS: Yes. I have a few words
to say which are not in this brief.

The cost of a plan like that is not
excessive. If you make a comparison with the plans
which exist in France or in Monaco, where I did practise,



Dreyfus 12531

the cost is very high due to insurance which pays the salary of the worker after the first day of illness. That is something with which the doctors have nothing to do. If we are thinking of health insurance plans, it is certainly not to pay the salary. In Saskatchewan, 16% is paid for that, which gives 50% of the salary after the first day, which makes the cost more.

THE CHAIRMAN: You are saying it should be after the first week?

DR. DREYFUS: We make something less gallant. The patient who is paying for the doctor and for the drugs can collect from the insurance.

THE CHAIRMAN: You don't mean that he will get a wage or part of his wage?

DR. DREYFUS: No. It is the cost of doctor fees and the cost of drugs. Such a plan exists in several countries; I hope it will come here, too.

I might say that the time will be excellent after the Blue Cross development, which has been fantastic, with the Ontario Hospital Services Commission, and many patients have to go to the hospital to get free drugs. Many of them are well-equipped, but they are overcrowded and, with the house visit, it will certainly help the hospital to make more scientific work than it does at the present time.

If you have to see a patient three times during the same week and he has to have paediatrics, and so on, for his children, it is around \$70, \$80 a week, so it is too high.

That is more or less all I have to say.



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Dreyfus

12532

THE CHAIRMAN: Thank you very much,
Dr. Dreyfus. We are quite pleased to have these individual submissions. We had one yesterday afternoon from a doctor, from the smaller centres in Ontario. Each time we get one of these individual submissions coming from people having tried to think out these problems by themselves, they are always ideas which, fitted with others, may eventually build up the crossword puzzle in the final solution. Thank you very much.

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12533

THE SECRETARY: Mr. Chairman, the next submission is from the Congress of Canadian Women, to be known as Exhibit 377, and Mrs. Rodd will speak to the submission.

--- EXHIBIT NO. 377:-- Submission of the Congress of Canadian Women.

SUBMISSION OF THE CONGRESS OF
CANADIAN WOMEN.

Appearances: Mrs. Nora Rodd
Mrs. Helen Kasian
Mrs. Alice Maigis

MRS. RODD: Mr. Chairman, members of the Royal Commission on Health Services, with me are Mrs. Helen Kasian and Mrs. Alice Maigis of the Association.

The Congress of Canadian Women submits the following summary of its brief on the problem of a Health Plan for the citizens of Canada. Health of mind and body is one of the most precious of all human possessions, and should be the right of every Canadian.

Since 1948 there has been a growing demand for a comprehensive Government Health Plan. Gallup polls taken at that time and since, show that the majority are in favour of it, including the doctors themselves. A poll taken by the Canadian Medical Association a little over a year ago shows that more than half of the 20,000 doctors replied and, of these, 93 percent stated they were willing to co-operate in any such government plan.



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CANADIAN WOMEN

Apparatus: Mrs. Rodd
Mrs. Helen Rodd

Mrs. Rodd: Mr. Chairman, members of

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Rodd

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The Plan has long been promised by government leaders. By Prime Minister Mackenzie King in 1948; by Prime Minister Louis St. Laurent in 1949 and '50 and by the Honourable Paul Martin in 1951. Much has been accomplished by the limited programs undertaken so far. Life expectancy has risen by an average of 8 years since 1937, and since 1927, deaths from tuberculosis have fallen from 18.7 to 4.6 per 100,000. Infant mortality has dropped from 45 to 37 per 1,000 live births, though it is still much too high - five times higher for Indian babies, and ten times higher for Eskimo babies than for white.

With the interests of women and children central in our work, we urge upon the Federal Government a much more extensive program for the care of mothers and children, including a network of maternity homes and mother and child clinics across the country. Such a plan would go a long way in preventing illness in later years.

We urge a plan including all medical care, medicines, hospitalization, home visiting service and optical and dental care for every citizen. A plan covering every illness - physical and mental, alcoholism, narcotism, social diseases. This plan will require training more doctors, nurses and technicians, for which scholarships, bursaries and much more free education will be necessary. It will include government-built and owned hospitals, clinics and consultation centres, and doctors like nurses will be paid salaries, as teachers are paid, by the government bodies. Nursing

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Rodd

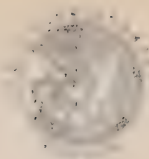
12535

must be given the status commensurate with its nobility. Young women must be paid adequately while in training, and graduate nurses' salaries be brought in line with those of other professions.

COSTS: CAN THE COUNTRY AFFORD IT?

A study of the British plan undertaken by Cambridge University in 1956 found that while costs rose as the population rose, the current net cost actually fell from 3 3/4 percent to 3 1/4 percent. In 1957 the Canadian Government began to share the cost of hospitalization with the provinces, both in order to provide the people with better health and to build a sound basis for hospital financing. However, the cost is still left largely to the patient, either by direct payment, or by voluntary insurance. And one-third of our people have no health protection of any kind. It is often impossible for older people to get health insurance (P.S.I., not after 56), and they are the ones who need it most.

One of the greatest wastes in our society is illness. When neglected it becomes chronic and brings on old age prematurely and poverty. Inflation is another cause of poverty, and so of ill health, and falls hardest on the elderly whose earning power is over. A chief offender in inflation is the vast arms program, producing nothing of economic value. We call upon the Government to direct part of this expenditure toward financing a comprehensive health plan, and to do all in its power to advance practical steps toward general, total and controlled disarmament.



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and graduate nurses' salaries be brought in line with
those of other professions.

COSTS: CAN THE COUNTRY AFFORD IT?

A study of the British plan undertaken
by Cambridge University in 1956 found that while costs
rose as the population rose, the current net cost
actually fell from 3 3/4 percent to 3 1/4 percent. In
1957 the Canadian Government began to share the cost of
hospitalization with the provinces, both in order to
provide the people with better health and to build a
sound basis for hospital financing. However, the cost
is still left largely to the patient, either by direct
payment, or by voluntary insurance. And one-third of
our people have no health protection of any kind. It
is often impossible for older people to get health
insurance (P.S.I., not after 65), and they are the ones
who need it most.

One of the greatest wastes in our
society is illness. When neglected it becomes chronic
and brings on old age prematurely and poverty. Infla-
tion is another cause of poverty, and so of ill health,
and falls hardest on the elderly whose earning power
is over. A chief offender in inflation is the vast
arms program, producing nothing of economic value. We
call upon the government to direct part of this expendi-
ture toward financing a comprehensive health plan, and
to do all in its power to advance practical steps toward
general, total and controlled disarmament.



Rodd

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TAKE THE PROFITS OUT OF MEDICINE

Today the medical profession has become a great empire built on sickness, with little incentive to keep people well. A comprehensive plan will lower the incidence of sickness by placing emphasis on prevention. Once the goal is health for all, all branches of the art of healing will have their place in co-operating to keep the people out of hospitals - the medical, osteopathic, chiropractic, homeopathic, etc., and smaller health centres over the country will bring specialists close to the people. Smaller hospitals and maternity centres caring for the immediate needs will result in fewer large hospitals and these will become more and more centres of teaching and research.

AN ALL-INCLUSIVE GOVERNMENT PLAN

The Congress of Canadian Women stands for a Comprehensive National Health Plan financed from the general revenue of the Government. A good beginning has been made in partial federal and provincial services. The extension of this principle to include complete health coverage for every person in the country, can help Canada to take the place that a young and richly endowed country should take among the nations today. "Programs of health and child welfare are indeed valuable investments in a country's human capital."

TO RECAPITULATE: The C.C.W. advocates:

1. A Comprehensive National Health Plan, financed from the general revenue of the Federal Government; a plan that will cover all illnesses,



Today the medical profession has become a great engine built on sickness, with little incentive to keep people well. A comprehensive plan will lower the incidence of sickness by placing emphasis on prevention. Once the goal is health for all, all branches of the art of healing will have their place in co-operating to keep the people out of hospitals - the medical, osteopathic, chiropractic, naturopathic, etc., and smaller health centres over the country will bring specialists close to the people. Smaller hospitals and maternity centres caring for the immediate needs will result in fewer large hospitals and these will become more and more centres of teaching and research.

AN ADDITIONAL GROUND FOR

The Journal of American Health Plans
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"Promotes of health and child welfare are indeed valuable investments in a lot of vital capital."

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Rodd

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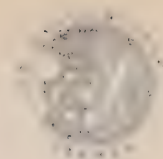
mental and physical, and will be
equally available to every citizen.

2. It will be a plan that will be
based on prevention and on smaller
health centres and will require
fewer large hospitals. Specialists
will be much more easily accessible
to the people.

3. A plan that will pay much
greater attention to mother and child
care, with maternity centres close
to the people.

To carry out such a plan the people
must have work and decent housing. They must not fear
old age or an impending war. A policy of peace and
disarmament will mean that vast sums now being spent
for purposes of war will be diverted to the needs of
the people, insuring the possibility of health minds
and bodies for young and old. Then truly will Canada
take her rightful place among the nations of the world!

Thank you Mr. Chairman and members of
the Commission.



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and bodies for young and old. Then truly will Canada
take her rightful place among the nations of the world!

Thank you Mr. Chairman and members of

the Commission.



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THE CHAIRMAN: Thank you, Mrs. Rodd.
The Congress of Canadian Women, can you tell us, for the record, just what the Congress comprises?

MRS. RODD: Yes, the Congress comprises chapters and friendly organizations across the country, and we work for two things especially, for the advancement of women and children and for peace.

THE CHAIRMAN: By and large, what membership do you purport to speak for?

MRS. RODD: Well, we do not have any definite membership, but we have centres in different cities and towns and we have groups of women who work with us when we put on drives and things like that.

THE CHAIRMAN: What kind of drives?

MRS. RODD: For old-age pensions, for better opportunities of education, for mothers' allowance and family allowance increases and, of course, for peace.

THE CHAIRMAN: How is your Congress supported or financed?

MRS. RODD: Well, we have when we have meetings we ask for donations.

MRS. MAIGRS: We have rummage sales and tea-parties, every penny comes out of our own pockets.

MRS. RODD: We always put on a big meeting across the country in different places for international women's day which is March 8, and that is one day we get a great deal of money.

THE CHAIRMAN: By voluntary subscription at the meetings?

MRS. RODD: Yes.



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THE CHAIRMAN: Thank you, Mrs. Gold.

The Congress of Canadian Women, can you tell us, for the

report, just what the foreign committee?

MRS. GOLD: Yes, the Congress committee

chapters and friendly organizations across the country,

and we work for two things essentially, for the advance-

ment of women and children and for peace.

THE CHAIRMAN: By and large, what

membership do you expect to break forth?

MRS. GOLD: Well, we do not have any

definite membership, but we have centers in different

cities and towns and we have groups of women who work

with us when we put on drives and things like that.

THE CHAIRMAN: What kind of drives?

MRS. GOLD: For college students, for

participation of education, for women's allowance

and family allowance increases and, of course, for peace.

THE CHAIRMAN: How is your Congress

supported or financed?

MRS. GOLD: Well, we have what we have

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MRS. GOLD: We always put on a big

meeting across the country in different places for inter-

national women's day which is March 8, and that is one

day we get a great deal of money.

THE CHAIRMAN: By voluntary subscription

at the rate of,

MRS. GOLD: Yes.



Rodd 12539

COMMISSIONER McCUTCHEON: I am very interested in one statement you made and I am sure the Canadian Government would be very interested if you could give them the answer to it. You say:

"In order to prevent even greater numbers of defective children being born, the Canadian Government must act for bringing about an immediate end to all nuclear testing."

I seem to recall that the Government has indicated that it was in favour of that; can you tell me how it could be accomplished?

MRS. RODD: Well, we asked the Government to act and we think they have been acting, but we want them to keep on acting, because we do believe ---

COMMISSIONER McCUTCHEON: By "acting" do you mean talking?

MRS. RODD: Among the nations, yes, and doing everything it can to keep itself away from any entanglements of that kind.

THE CHAIRMAN: Thank you, Mrs. Rodd. I think there was some little misunderstanding about sending in the brief, this only arrived this morning.

MRS. RODD: Yes, we thought we had until the 15th of June, we understood your program had been filled up until the 15th of June, so we thought we had quite a bit of time. We had our work pretty well prepared at that time, but we did not send these in until I brought them.

THE CHAIRMAN: We are honoured that you were able to arrange to make the presentation. As you





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TORONTO, ONTARIO

Rodd 12540

can understand, looking back to April, we had a volume of submissions for Toronto and of course, as we go along a certain number of people do not present briefs which they had anticipated presenting and we have to change the schedule around. We are now coming to the close of the hearings in Toronto. Thank you very much for being able to accommodate yourselves in coming this morning.

MRS. RODD: Thank you, we were very glad to come.



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schedule around. We are now coming to the close of the
season in Toronto. Thank you very much for being able
to accommodate yourselves in coming this morning.
MRS. ROSE: Thank you, we were very

glad to come.



12541

S U B M I S S I O N O F
DOCTOR CLARE S. SANBORN

DR. SANBORN: I am sorry I have not with me this morning, due to various factors, one of which is lack of time, a formal brief for you. However, I should like to make a few comments and I should like to make a recommendation, at least, I have been given to understand from various sources that a recommendation would be accepted or welcomed.

I believe that in any prepaid medical care scheme that the medical component of that scheme should be entirely the province and the responsibility of doctors of medicine. I believe the business part of the scheme and its structure should be the responsibility of men well-versed in business administration and having a very thorough knowledge of that great field which we call insurance.

I am sure we all believe that every citizen should receive the best possible medical care in spite of his ability to pay. For those who are so unfortunate as to find the payment of medical care a burden, I would leave the decision of the solution of their problem, being a doctor, to other interests; one is the businessman and the insurance man and the other is the man or the leader of the man who is involved in the politics of the problem.

But, as a doctor, I am sure I can say with the greatest sincerity and truth that whatever scheme



DR. CHURCH: I am sorry I have not

with us this morning, due to various factors, one of which is lack of time, a formal letter for you. However, I should like to make a few comments and I should like to make a recommendation, at least, I have been eager to understand from various sources that a recommendation would be accepted or welcomed.

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But, as a doctor, I am sure I can say

with the greatest sincerity and truth that whatever scheme



Sanborn

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is evolved the doctors of this country will look after the patient and that to the best of their ability.

My discussion this morning, which I find a great psychologic burden, has to do with that prepaid medical plan known as Windsor Medical Services Incorporated. This is a plan that has been widely advertised as being as close to the ideal as is possible to approach. I have been a director of this corporation for two separate terms and I have been a student of its operation for twenty years and have practised for twenty years under this difficult contract.

THE CHAIRMAN: You practise in Windsor?

DR. SANBORN: I practise in Windsor, sir. There are men here, at least one man who repeatedly has attended the annual meeting of the Windsor Medical Services Incorporated and he knows that from year to year I have presented its defects in a friendly, constructive sort of way. I am sure he realizes that no figures which I have ever quoted have been questioned.

This morning I should like to bring to your attention what I believe to be the truth that any system or plan of insurance or medical care which discriminates against a portion of its membership causing among them dissatisfaction, frustration and disappointment, will depreciate and deteriorate the quality of medicine practised in the district in which they serve. It does that in various ways, but for the last twenty years actually hundreds of doctors have come into the counties of Kent and Essex but for ten years not one internist put foot inside the doors of Windsor, because they knew of the unfair schedule of fees --- not in ten years.



/hm

Sanborn

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4 DR. SANBORN: Then in the last ten
5 years, I would say, approximately six or seven men
6 have come and these are fine men. Several of them have
7 the best degree that is obtainable in Canada. They have
8 Fellowship in the Royal College. They are devoted
9 men and they are dedicated men.

10 Why did they come when others have
11 shunned the place for years? I can only say that they
12 came because they originally had left Windsor. They
13 thought they were coming back home to get a good
14 welcome. A place where they had acquaintances. A place
15 where they would be at home.

16 As I say, I presented all the complaints
17 and much more than I will present this morning but when
18 I read several weeks ago that Mr. Sania who is in the
19 Social Department of the University of Michigan, full
20 time man there, would be assisting in the production of
21 a brief to this body, I felt that I should also present
22 some things that I was quite sure would not be presented.

23 I should like to deal first with the
24 autocratic, arbitrary type of administration. As I
25 said before, and probably I should say again before I
26 am through, my comments have been entirely confined to
27 the men of medicine for 20 years. I have a great many
28 friends in Windsor. In that community where \$6 million
29 is divided amongst 430 doctors, community where the
30 patients do not file a bill for service or that sort
of thing, I have complaints of these things and realize
at least 300 of those men will not be too fond of the
fact that I am laying before you what I consider the defects



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automatic, arbitrary type of administration. As I said before, and probably I should say again before I am through, my comments have been entirely confined to the men of medicine for 20 years. I have a great many friends in Windsor. In that community there 25 million is divided amongst 450 doctors, community where the patients do not file a bill for service or that sort of thing, I have complaints of these things and realize at least 300 of those men will not be too fond of the fact that I am laying before you what I consider the basic



Sanborn

12544

1 of the system and which I have presented to them.

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4 So that if anyone thinks I have come
5 here to make friends, I am sure they are profoundly
6 mistaken and that is one of the things that considerably
7 concerns me sir. The arbitrary and the autocratic
8 conduct of the business of this organization is such it
9 has deteriorated -- I call it deterioration -- because
10 we now find that the president, who usually is quite
11 willing to run again, has the power and has the sole
12 power to appoint the chairman of the Nominating Committee
13 and all that that infers and having the elections,
14 election being over and a few people are elected, the
15 president of this corporation appoints himself the
16 members of the Medical Control Committee.

17 THE CHAIRMAN: Dr. Sanborn, evidently
18 you have some matters that you want to air. The question
19 arises as to whether this is the place to do it. We
20 are here to enquire into the problem of health services.
21 Now, we have had individual submissions in the odd case,
22 in some isolated instances even had complaints and that
23 kind of thing but I would judge from what you have said
24 so far that your grievances appear to be within your
25 own organization.

26 DR. SANBORN: Well, Mr. Chairman, I
27 appreciate your comment on that.

28 THE CHAIRMAN: Just hear me out.

29 DR. SANBORN: Yes sir. I thought you
30 were through sir.

THE CHAIRMAN: I think I must say to
you that it is not within the scope of our enquiry to



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Sanborn

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4 pass upon or to be of any assistance to any one in the
5 settling of what may be an internal problem within any
6 one organization.

7 Now, I cannot say that there is no
8 possibility of relevancy, because these doctor-sponsored
9 or co-operative insurance prepayment plans are within
10 the scope of our enquiry but we are more concerned with
11 them in their relationship with the public for whom
12 they provide or assist in paying for medical services
13 rather than the internal workings and any difficulty
14 that there may be between the profession and the plan.

15 DR. SANBORN: I see your point sir.

16 THE CHAIRMAN: So that if what you
17 wish to discuss relates to its operation insofar as the
18 public is concerned, and that the service to the public
19 is not as good as it should be or might be better, then
20 we must necessarily hear you.

21 If it is a matter of an internal
22 struggle between yourself and some individuals in the
23 organization, then that is something that has to be
24 thrashed out at an annual meeting, or something of that
25 kind and we can be of no help to you.

26 DR. SANBORN: May I ask you one question
27 sir?

28 THE CHAIRMAN: Yes.

29 DR. SANBORN: If I express it first
30 a doctor cannot do good work.

THE CHAIRMAN: All right, that is fair
enough. That has relevancy. It must be related to the
public. Now, if you could bring yourself to state that



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Sanborn

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1 point, please do so.

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4 DR. SANBORN: I think you are entirely
5 right sir and I think that I have -- this problem, of
6 course, has been very vexing to me. My submission is
7 that the internist and the general practitioners, the
8 family doctor who makes the house calls and office calls,
9 the man who listens to the patient, the man who spends
10 time on the patient, visits him at night, the very
11 vanguard of the practice of medicine is being discriminated
12 to the extent that Windsor Medical pays these men 50%
13 less than the average doctor across Canada.

14 THE CHAIRMAN: You say that has a
15 debilitating effect on the practice of good medicine?

16 DR. SANBORN: I do sir. It doesn't
17 pay them a living wage sir. May I say that as a specialist
18 working 60 hours a week, I make \$2.10 an hour and my
19 patients, a man came to me at Christmastime, if I may
20 just say this sir, a man facing retirement having a coronary
21 and he came to my home with an envelope. He said Doctor
22 my family trust that you will not take offence at this.
23 That we have done anything that might interfere with your
24 private feelings. Please do not open this letter until
25 I have gone. This is not the only case sir and after
26 he had left there was \$100.00 in the envelope and he
27 said when we found out from Windsor Medical the amount
28 that we would receive for tax deduction for illness, in
29 other words, for your service, we were simply appalled.

30 Now I maintain that you cannot deteriorate,
frustrate and fatigue a doctor and get the best medical
service in the community. Thank you sir.

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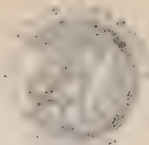
Sanborn

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THE CHAIRMAN: Thank you very much

Dr. Sanborn. We will now take a brief recess.

---Short recess.



THE CHAIRMAN: Thank you very much

Dr. Sanborn. We will now take a brief recess.

---Short recess.



I2548

THE SECRETARY: Mr. Chairman, the next submission is a private brief from Doctors Bodrug, Vozoris, Magder, Godfrey and Pilkey, and will be known as Exhibit 378.

---EXHIBIT NO. 378: Submission of Doctors Bodrug, Vozoris, Magder, Godfrey and Pilkey.

S U B M I S S I O N O F
DOCTORS BODRUG, VOZORIS, MAGDER, GODFREY AND PILKEY

APPEARANCES:

DR. A.G. BODRUG,
DR. J. MAGDER,
DR. C.M. GODFREY.

DR. GODFREY: I would like to present Dr. Magder and Dr. Bodrug, who are sitting here with me.

THE CHAIRMAN: Thank you.

DR. GODFREY: Sir, this is a private brief to endorse a comprehensive plan.

We endorse a comprehensive plan based on the twin principles of health care for all, regardless of income, and on the cost being shared by all, using the general tax machinery to ensure that individual payments are related to ability to pay.

The plan should be -

1. Comprehensive and cover all Canadian residents.
2. Administered by the Provinces in cooperation with the Federal Government.

12548

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next submission is a private brief from Doctors Bodrug,
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The plan should be -

Comprehensive and cover all Canadians

Administered by the Provinces in

cooperation with the Federal Government



Godfrey 12549

3. Financed jointly by the Federal and Provincial Governments, and since the Federal Government's share will be drawn from general revenues it will fall on individuals by and large in proportion to their ability to pay.
4. One in which not only medical, surgical, obstetrical and psychiatric care are included, but also optical treatment and glasses, dental care and essential drugs and appliances on prescription.
5. Based on the maintenance of good relations between the doctor and the patient, the latter being free to choose their own physician. Doctors being paid by fee for service although the bills will actually be met by an independent agency of the Provincial Government.
6. Free from interference with the Doctor's practice of medicine and with medical decisions remaining entirely under the control of the medical profession.
7. Extended to include financial assistance to teaching and research facilities, and to the training of doctors, nurses, dentists, technicians and other health personnel.

This brief is respectfully submitted, sir.

THE CHAIRMAN: Yes, Dr. Godfrey. Now, would you just tell us who you are, in the sense do you



1934

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Godfrey 12550

practise together as a group?

DR. GODFREY: No, sir. We are a group of physicians who have been concerned with these problems, and have felt that private briefs should be presented along with organized briefs from other organizations of medicine.

THE CHAIRMAN: Private briefs were invited.

DR. GODFREY: Yes, and we responded to that invitation.

Although we endorse certain sections of the brief of the Canadian Medical Association, we consider our point to be very important and that we must do more to enlarge the present health services which are available. We feel the most important thing at the present is some feature which will enable the patient to pay for his medical care. This is our number one choice. This has been sponsored by a group of physicians who feel alike in this matter, and indeed it is not only in Toronto, but all over the country.

THE CHAIRMAN: Just a minute at that stage. You say a group. Would you put numbers on that?

MR. GODFREY: A group of ten were the nucleus for this in Toronto, but since then we have circularized throughout the country and we have some fifty signatures to these principles in general.

THE CHAIRMAN: Fifty out of how many in Ontario?

DR. GODFREY: No, sir, across the whole country.



Godfrey 11553

practise together as a group?

of physicians who have been concerned with these problems,

and have felt that private briefs should be presented along with organized briefs from other organizations of

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THE CHAIRMAN: Fifty out of how many

in Ontario?

DR. GODFREY: No, sir, across the

whole country.



Godfrey 12551

THE CHAIRMAN: Fifty out of 17,900 or so?

DR. GODFREY: That is right, sir.

THE CHAIRMAN: I mean, those are round figures that have been given to us as the number of practising physicians in Canada. I don't give it as a completely accurate figure.

DR. GODFREY: Yes, sir. I don't intend to apologize for it being 50 signatures. We wanted a little more support, and we didn't circularize all the people by any means.

THE CHAIRMAN: Well now, who did you circularize?

DR. MAGDER: We approached people who we felt were interested in supporting our original petition, and those only. We didn't approach any individuals who ----

THE CHAIRMAN: Is this putting it correctly? That you approached those you thought were of like mind?

DR. MAGDER: Exactly.

DR. GODFREY: Yes, sir.

THE CHAIRMAN: Well now, yourself, Dr. Godfrey, do you practise here in Toronto?

DR. GODFREY: Yes, sir.

THE CHAIRMAN: In what branch of medicine?

DR. GODFREY: I am a specialist in physical medicine and rehabilitation, sir.

THE CHAIRMAN: Are you connected with



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medicine?

DR. GODFREY: I am a specialist in

physical medicine and rehabilitation, sir.

THE CHAIRMAN: Are you connected with



Godfrey 12552

any particular institution?

DR. GODFREY: I am connected with the University of Toronto, sir, and several of the hospitals in the East end of Toronto. Would you like me to name them, sir?

THE CHAIRMAN: No, that is all right. Dr. Magder, what is yours?

DR. MAGDER: I am a general practitioner, practising in the Scarborough area of Metropolitan Toronto, and I am associated with two hospitals in that region.

THE CHAIRMAN: And Dr. Bodrug?

DR. BODRUG: I am a general practitioner, practising in the East end of Toronto.

THE CHAIRMAN: Were you the gentleman I had the pleasure of seeing on TV the other night?

DR. BODRUG: Yes, sir.

THE CHAIRMAN: Now, you recommend payment on a fee for service basis, with the bills being paid by an independent agency of Government, you say of the Provincial Government, but an independent agency. Where would the agency get the money to pay the bills? I mean, on the fee for service basis?

DR. GODFREY: I regret to say, sir, we are not entirely agreed on this matter. We agree on the general principle of the patient receiving monies in order to pay his medical fees.

THE CHAIRMAN: The patient receiving monies?

DR. GODFREY: Yes, sir. If I may go on, sir ----

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THE CHAIRMAN: And Dr. Wagner?

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Godfrey 12553

THE CHAIRMAN: "I just don't follow you.

COMMISSIONER McCUTCHEON: That is not what you say in the brief.

DR. GODFREY: This is a general brief, sir. If I may expand on that particular item, my personal opinion is that all persons in the country would be required to have an insurance policy with coverage as set out in Clause 1. Such policies could be purchased from private carriers, or from a health insurance commission. Such a commission would be set up in a similar fashion to the present Ontario Hospital Services Commission. On the basis of income tax returns, those citizens earning below a level to be determined would have an insurance policy provided by the Health Insurance Commission. The premiums would be paid from general tax revenue.

THE CHAIRMAN: What do you mean by premiums would be paid? Oh, that is for those below this level?

DR. GODFREY: Yes, sir.

THE CHAIRMAN: But for those above that level?

DR. GODFREY: A person paying for his own insurance could deduct the premium from his taxable income. Every encouragement would be given to the formation of non-profit insurance schemes, which would offer full coverage to any citizen wishing to purchase a plan.

THE CHAIRMAN: Of course you will appreciate that you flesh the thing out much more than the



Today

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Godfrey 12554

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4 basic proposition here. You are talking now of the
5 premium-based system for those who can afford the premium,
6 with the State paying for those who cannot?

7 DR. GODFREY: Yes, sir.

8 THE CHAIRMAN: And that necessarily
9 brings us to this problem that everybody has to face the
10 moment you mention premium, which is how do you identify
11 those who cannot from those who can?

12 DR. GODFREY: I believe, sir, on the
13 basis of income tax return those citizens earning below
14 a level to be determined would have an insurance policy
15 provided by the Health Commission.

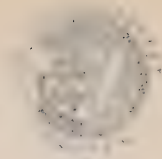
16 THE CHAIRMAN: Who would make that
17 determination?

18 DR. GODFREY: I think this would be
19 in the future a job in the Commission. Presumably, speak-
20 ing very roughly, I think a person married with one child
21 who makes \$4,800.00 a year should be able to buy his own
22 insurance. This is a rough measurement, sir. This is
23 a basis on which we would proceed, on the same basis I
24 presume, as who determines income tax requirements.

25 THE CHAIRMAN: The amount of money
26 paid the doctor, would you operate on some provincial
27 schedule of fees, such as the Ontario Medical, or whatever
28 it might be?

29 DR. GODFREY: Yes, sir, this would be
30 the suggestion.

THE CHAIRMAN: And supposing the amount
of money was not sufficient, would you either have to pay
the doctor less, or increase the premium?



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DR. COOPER: Yes, sir.

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Godfrey 12555

DR. GODFREY: I think the premium would have to be increased, as has happened with the Ontario Hospital Services Commission. If there is not sufficient money to pay for hospitalization procedures which are required, then more money is raised.

COMMISSIONER McCUTCHEON: The premium has not been raised in Ontario.

DR. GODFREY: I believe there has been a special tax invoked, is that not right, sir, in order to provide more revenue for the Ontario Hospital Services Commission?

COMMISSIONER McCUTCHEON: No revenue is earmarked for the Hospital Services Commission other than the premium.

DR. GODFREY: Well, I stand corrected, sir.

THE CHAIRMAN: Certainly the amount of the premium has not been increased. Have you anything to add to this, Dr. Magder or Dr. Bodrug?

DR. MAGDER: Mr. Chairman, as Dr. Godfrey mentioned, we all accept the basic principles which we presented to you. However, we have different feelings as to ways and methods of bringing about these principles.

My feeling, on the basis of what has just been discussed, differs from Dr. Godfrey's. I feel that in order to bring about the comprehensive plan, a one-agency compulsory method of insuring of individuals within the Province, if you want to relate it to the Province, would probably be more satisfactory, be that a Government-supported agency, a Government agency, or a non-



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Magder 12556

profit agency with Government, some Government regulation, and the finances for that agency would be derived from one premium.

Number two, Provincial funds available from Provincial taxation as well as Federal assistance through general tax revenue.

Individuals who could not pay the premium for some reason would have that premium, perhaps paid at municipal level, much as our present welfare system permits at the present time, but I believe in one agency rather than several agencies.

THE CHAIRMAN: Yes, you say one premium. Are you talking about premium on an actuarial basis? That is, on what the real cost is?

DR. MAGDER: No, the premium should be part of the true cost. I don't feel that the premium could ever be adjusted, or assessed to pay true cost. I think premium should be part of the cost and tax monies be used to pay the rest of the cost.

THE CHAIRMAN: Would you contemplate that this premium would be subsidized? I mean, down from the actual cost to a figure at which the great majority could pay?

DR. MAGDER: I think the premium should be a premium that the great majority could pay, and those who could not pay the premium would have it partly subsidized, or perhaps completely paid for through existing welfare setups.

THE CHAIRMAN: Who would take care of the deficiency, because if you bring a premium down to the



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Meyers

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THE CHAIRMAN: Yes, you say one premium.
Are you talking about premium on an individual basis? Is
it, on what the cost is?

Dr. HADLEY: Yes, the premium would be
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be used to pay the rest of the cost.

THE CHAIRMAN: Would you contemplate
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existing welfare system.

THE CHAIRMAN: Who would take care of
the deficiency, because if you bring a premium down to the



Magder 12557

level at which the great majority can pay, it is going to be below actual cost, is it not?

DR. MAGDER: Well, exactly, and I feel that the additional cost should be provided through Provincial and general revenue.

THE CHAIRMAN: Are you aware that you have stated, in very general terms, the proposition put forward by Premier Roblin of Manitoba?

DR. MAGDER: No, I am not, sir.

THE CHAIRMAN: With some variations, but basically that idea of premium with possible payment by the great majority, those who cannot pay to have the premium paid for them by the State, and subsidization of the program to bring this premium down to the level where most can pay.

DR. MAGDER: I was not aware of that, sir. I realize he had presented a brief, but I was not aware of it.

THE CHAIRMAN: You realize, of course, that you and Dr. Godfrey are a thousand miles apart?

DR. MAGDER: Yes, but we are still together on the principle.

COMMISSIONER McCUTCHEON: The principle is that the doctors are to be paid, is that right?

DR. MAGDER: That is the principle.

DR. GODFREY: Oh, I don't think that is fair.

DR. MAGDER: But for a reason, to provide health services.

THE CHAIRMAN: Now, Dr. Bodrug, what is

level at which the great majority can pay, it is going

to be below actual cost, is it not?

DR. HARTMAN: Well, exactly.

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provide health services.

THE CHAIRMAN: Now, Dr. Goffrey, what is



Bodrug 12558

your position? Do you agree with either one of them,
or have you got one of your own?

DR. BODRUG: I agree with Dr. Magder,
sir.

THE CHAIRMAN: Is there anything else
you want to add, because these individual opinions, they
are always a source for causing people to think. I mean,
I don't suppose we are able to just reach up into thin
air and bring down a program that is completely acceptable
to everybody, but the more people we get thinking about
it and coming up with original ideas, the closer we can
come to finding a solution, and therefore individual
thinking on this is most important.

DR. BODRUG: Mr. Chairman, to tie up
the loose ends, this was a quite involved and not clearly
stated form.

In my opinion, everybody who is able
to pay a basic premium whether it is in one category or
another, a single man, a married man with children, but
nevertheless each should be paid to completion by the
two upper levels of Government, that is Provincial and
Federal, and those who are unable to pay at all will be
subsidized by some method worked out between all parties.

THE CHAIRMAN: Well, that is substantially
what Dr. Magder said?

DR. BODRUG: Yes.



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DR. ROBERTS: I agree with Dr. Wagner.

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local, and those who are unable to pay at all will be

sustained by some method worked out between all parties.

THE CHAIRMAN: Well, that is substantially

what Dr. Roberts said.



COMMISSIONER McCUTCHEON: There is a great difference between Dr. Godfrey's plan, as I understand it; it involves people only below a certain income level, otherwise people pay in full.

DR. GODFREY: Yes, sir.

COMMISSIONER McCUTCHEON: The only question is if one becomes insolvent on that basis, what happens?

DR. GODFREY: Yes, sir, and I appreciate that as a major concern in the matter of how much health we can afford.

THE CHAIRMAN: Would you go so far as to say that there would have to be prorating by the doctors?

COMMISSIONER McCUTCHEON: And the dentists.

DR. GODFREY: You mean a prorating of fees received?

THE CHAIRMAN: Yes.

DR. GODFREY: I think this would be well in the minds of those who were setting the fees. The fee set by the Association is not an absolute thing whereby they say we want \$50.00 for this. It is taking into consideration the economy of the country, and so on. If this scheme were making the country bankrupt, then, of course, there would have to be adjustments made.

THE CHAIRMAN: Adjustments in what way?

DR. GODFREY: In the amount of income.

THE CHAIRMAN: Those furnishing the



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THE CHAIRMAN: Those including the



Godfrey

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3 service?

4 DR. GODFREY: Yes, sir.

5 THE CHAIRMAN: Who would impose this
6 reduction?

7 DR. GODFREY: I think it would be
8 self-imposed.

9 THE CHAIRMAN: Suppose we were a little
10 bit selfish and said we were not going to do that?

11 DR. GODFREY: I am sorry, but I have
12 to be a little bit stiff on that and say I don't accept
13 that. I think the fees have been reasonable, and it
14 would be unfair to suggest that they would not be
reasonable in the future.

15 THE CHAIRMAN: Suppose somebody came
16 along and said this year things haven't been too good,
17 taxes are slow and gives you 20%?

18 DR. GODFREY: Physicians have accepted
19 far lower to make the scheme work.

20 THE CHAIRMAN: They have accepted 87%,
21 88%, 89% of billed accounts.

22 DR. GODFREY: Yes, sir.

23 THE CHAIRMAN: Suppose somebody came
24 along and said 20%? Don't you see that this is in the
25 realm of possibility, that if you give somebody authority
26 to prorate, when the authority is there, what control
is there over the exercise of it?

27 DR. GODFREY: I appreciate your point
28 and see it now. Any authority that would have to be
29 given, it would be freely given, by the physicians, to
30 have it prorated.

Godfrey

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Godfrey

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4 THE CHAIRMAN: Do you see that being
5 done by an agency?

6 DR. GODFREY: It depends on the agency.
7 If there was sufficient confidence in the agency, it
8 would be freely given and we have faith in the people
9 operating it. But this would not apply to other agencies
10 which I am sure come to mind quite readily at the
11 moment.

12 COMMISSIONER McCUTCHEON: Do you have
13 the same faith in governments generally?

14 DR. GODFREY: I have a reasonable
15 amount of faith in the government, sir.

16 COMMISSIONER McCUTCHEON: I would like
17 to ask what Dr. Bodrug and Dr. Magder have to say,
18 because their subsidization is going to apply to everybody
19 in the community, rich or poor, there is going to be a
20 substantial amount of money in there. How can you
21 reconcile that with freedom from interference with the
22 doctor's practice? You are familiar, I take it, with
23 the provision in the Saskatchewan Bill which authorizes
24 the cabinet to fix medical fees.

25 DR. BODRUG: Mr. Chairman, I might ---

26 THE CHAIRMAN: I think you have not
27 stated it quite correctly -- authorized by the cabinet,
28 which by regulation authorizes the commission.

29 COMMISSIONER McCUTCHEON: No, but the
30 commission's decision must be confirmed by the cabinet.

THE CHAIRMAN: It is the commission's
decision initially.

COMMISSIONER McCUTCHEON: Yes, which



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moment.

COMMISSIONER McINTOSH: We have

the same faith in government's generalities?

MR. GODFREY: I have a reasonable

amount of faith in the government, sir.

COMMISSIONER McINTOSH: I would like

to ask what Mr. Godfrey and Mr. McIntosh have to say,

because their participation is going to apply to every body

in the community, man or woman, there is going to be a

substantial amount of money involved. How can you

reconcile that with the fact that the government with the

doctor's practice? You are familiar, I take it, with

the provision in the Saskatchewan Bill which authorizes

the cabinet to fix and set fees.

MR. GODFREY: Mr. Chairman, I think --

THE CHAIRMAN: I think you have not

stated it quite correctly -- authorized by the cabinet,

which by regulation authorizes the commission.

COMMISSIONER McINTOSH: No, but the

commission's decision must be confirmed by the cabinet.

THE CHAIRMAN: It is the commission's

COMMISSIONER McINTOSH: Yes, which



Godfrey

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3 the cabinet can approve or disapprove.

4 DR. BODRUG: I might be unique, but
5 I have a great deal more faith in governments than most
6 people. I believe in the justice of man and I feel that
7 a government in a country such as ours would see that
8 the person giving the service would receive adequate
9 remuneration. However, in order to clarify this
10 remuneration, I feel that when the commission was set
11 up there could be some method of arbitration which could
12 be invoked, such as the Supreme Court, and after
13 examining all the facts, and so on, their decision could
be final.

14 COMMISSIONER McCUTCHEON: You are
15 substituting the Supreme Court for parliament insofar
16 as raising taxes and so on.

17 DR. BODRUG: I would say that the
18 government would raise the taxes.

19 THE CHAIRMAN: Would you apply that
to other segments of the economy?

20 DR. BODRUG: Some, yes, sir.

21 THE CHAIRMAN: Labour?

22 DR. BODRUG: Yes, sir.

23 THE CHAIRMAN: Compulsory arbitration
24 of wage schedules?

25 DR. BODRUG: Not as a choice in every
26 case, but in some cases.

27 THE CHAIRMAN: In what cases?

28 DR. BODRUG: Well, they would have to
be judged on their particular merits as they arose.
29 I think in cases where the actual welfare of the entire
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I think in cases where the actual welfare of the entire



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community is concerned, in cases of essential services.

THE CHAIRMAN: Railways for instance?

DR. BODRUG: It has been done; I think it was the only course under the position as it occurred then. But we would hope that before arbitration was necessary agreement could be reached.

DR. GODFREY: I would point out, sir, if I might that we are very much aware, all of us, of our shortcomings as far as being able to manipulate finances, because we are essentially physicians, and actually to call upon us to give a scheme for the country, we are not equipped for it, this was not part of my training at the University of Toronto, and perhaps it may be a little bit presumptuous, except those concerned with government, but we have been pulled into this. The quality of care will be controlled by the quality of government in a scheme such as this.

THE CHAIRMAN: You accept that as inherent in any form of government scheme, that control will affect quality?

DR. GODFREY: Yes, sir.

COMMISSIONER McCUTCHEON: And that control of some measure even under your scheme, Dr. Godfrey, is inevitable?

DR. GODFREY: Yes. We do have to have some control. I would hope that the control of the quality of care would be controlled by the licensing profession. The patient as the ultimate consumer can control it, through the government.

THE CHAIRMAN: Well, we are grateful



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4 to you, gentlemen. These are matters of importance. We
5 are very glad to have your views, and from the many
6 opinions we have heard we may be able to work out a
7 composite pattern that will have general acceptance and
8 general beneficial results to the consumer, and we are
9 grateful to you for having come here this morning.
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PM/hm

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THE SECRETARY: Mr. Chairman, the next submission is that of the Committee for the Furtherance of Creative Research in the Pharmaceutical and Allied Industries and it will be known as exhibit number 379.

---EXHIBIT NO. 379: Submission of Committee for the Furtherance of Creative Research in the Pharmaceutical and Allied Industries.

SUBMISSION OF
COMMITTEE FOR THE FURTHERANCE OF CREATIVE
RESEARCH IN THE PHARMACEUTICAL AND
ALLIED INDUSTRIES

APPEARANCES:

Mr. Andre Forget

THE CHAIRMAN: Yes, Mr. Forget.

MR. FORGET: Mr. Chairman and Members of the Commission: The submission I think has been in your hands for a little time and I do not propose to read it into the record because I think that is a rather useless procedure.

If I may I would just summarize the points that are made in the brief. The brief is divided into three parts; first is the introduction and it is submitted on behalf of a committee which is called the Committee for Creative Research in the Pharmaceutical and Allied Fields. Now, this committee is composed of 27 companies and they are listed in appendix A to the brief. You will note they represent a very substantial



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4 segment of the pharmaceutical and chemical industries
5 in Canada.

6 It is the view of the committee that
7 in order to achieve a high standard of health in Canada
8 a sound Canadian drug industry must exist. It is the
9 Committee's view that reliance on imports for drugs is
10 risky because if there were an emergency the availability
11 of imported drugs might be in question.

12 In the introduction to this brief
13 the Committee points out also that with imports of
14 drugs, if Canada were relying on imports of drugs rather
15 than on local manufacturers, one would practically
16 eliminate research in the drug field in Canada. It is
17 a pity today, according to some statistics, that half
18 our Ph.D.s in chemistry move to the United States. The
19 universities are worried because we are training, at
20 huge cost, technicians of great skill that are later
21 lost to us.

22 Now, I am not going to discuss patents
23 in general but one of the things that worries the
24 Committee is the weakness of our patent system when it
25 comes to drugs. I will come to that in greater detail
26 later. It is the Committee's point of view that drug
27 patents should be certainly no weaker than ordinary
28 patents.

29 In the second part of the brief there
30 are listed a number of factors affecting the drug
industry which are sometimes forgotten or lost sight of.
The first one is the very nature of the product of the
industry as a preventative of disease and restorer of

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4 health. It is obvious that the aim must be to have these
5 products made available to every Canadian at reasonable
6 prices and the drug industry, at least that segment of
7 the industry for whom I speak, is not advocating the
8 abrogation of sections 66 and following of the Patent
9 Act, which sections, as you know, make compulsory, make
10 licensing compulsory not only for drug patents but for
11 every patent after three years if the Canadian demand
12 has not satisfied a reasonable demand from Canadian
13 sources. It is not our recommendation that these be
14 abolished.

15 The nature of the product makes it
16 imperative that there be availability from Canadian
17 sources. The second point is that research is vital
18 in the drug industry and, unfortunately, very little
19 research is done in Canada in drugs. Most of the research
20 is done in the United States where at least 10% of every
21 drug dollar goes back into research. I have no figures
22 for Canada but they are much less, very much less. As
23 I was saying before, we are losing our best brains in
24 the chemical field, in the pharmaceutical field to other
25 countries. I say that research must be encouraged and
26 I believe that the weakness of the drug patents is one
27 of the factors that influence companies not to interfere
28 and not to research in this country. The importance of
29 research in Canada has been stressed in many ways lately.

30 THE CHAIRMAN: Do you intend to say
why?

MR. FORGET: Yes, I will come to that
later in the submission. Last year the Income Tax Act

health. It is obvious that the aim must be to have these products made available to every Canadian at reasonable prices and the drug industry, at least that segment of the industry for whom I speak, is not advocating the annihilation of sections 20 and following of the Patent Act, which sections, as you know, make compulsory, make licensing compulsory not only for drug patents but for every patent after three years if the Canadian demand has not satisfied a reasonable demand from Canadian sources. It is not our recommendation that these be abolished.

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THE CHAIRMAN: Do you intend to say

MR. TORRETT: Yes, I will come to that.

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was changed to eliminate the ceiling that used to exist on research costs as deductible expenses from taxable income on companies in the year. There was a suggestion that companies would be able to deduct 150% of research costs as encouragement towards research.

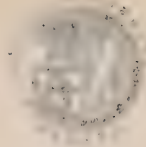
COMMISSIONER McCUTCHEON: Costs or costs of new facilities?

MR. FORGET: New facilities. I have not all the details with me.

THE CHAIRMAN: In Canada?

MR. FORGET: In Canada, yes. And now, research is extremely important in the drug field and it has been said in the United States only one drug in 2,800 gets to the prescription stage, they fall by the wayside in clinical testing or toxological testing and so forth.

Another factor that is peculiar to the drug industry is the very long time it takes to put the drug on the market. It has been estimated it takes five years and some say it takes 15 years of research before it may be marketed. That is a condition that is peculiar to the drug industry and that condition is perhaps aggravated by an opposite condition and that is a very short time during which a drug is likely to remain on the market; because of progress in the drug field being so rapid and a new therapeutic technique anywhere in the world can put a drug off the market overnight. For instance, cortisone stayed on the market ten years and it has been replaced by different varieties of the same drug. It is obvious with the



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3 finest research that has been done in a country such
4 as the United States, Britain, Switzerland and elsewhere,
5 you will have an extremely short useful life of a drug
6 on the market.

7 Another factor is quality control and,
8 of course, quality control must be absolute. If I
9 manufacture a fountain pen and it is defective I can
10 replace it but you cannot replace a man's life and
11 quality control takes an awful lot of the cost from the
12 drug.

13 Another thing is that many companies
14 carry rare drugs for rare illnesses, antivenoms and they
15 do this as a public service. Sometimes people forget
16 that. If there were an epidemic of some kind we could
17 find in Canada enough of these drugs without having
18 to import them.

19 Then there is another factor, the
20 very intense competition that exists as between drugs.
21 We have for instance the tranquilizer field and now
22 there are some 25 or 30 on the market which compete
23 with each other, each having similar properties but not
24 exactly the same, of course. It is obvious that all these
25 factors affect the risk of investing capital in drug
26 research.

27 I come now to the patent system and
28 how it affects this position. The present patent system,
29 as it deals with the drug industry, discourages research
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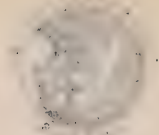
THE CHAIRMAN: Just say section 41.

MR. FORGET: Section 41 of the Patent Act, of course, precludes an inventor of a drug made by chemical process from obtaining a patent on the drug unless the process itself is new and patentable. In other words, I can invent anything new and get a patent for it but not a drug made by chemical process and since most of the drugs are as the result of chemical process you find very often patents can be obtained in Canada for drugs but if they are obtained they are of doubtful validity because of section 41.

THE CHAIRMAN: Is there any substantial difference between what you may patent in the United States than in Canada?

MR. FORGET: Yes, in the United States you can patent drugs, section 41 has no equivalent in the United States. It was this section 41 that was enacted after the First World War when the British were under the tutelage of Germany in chemicals and particularly in dyestuffs and as part of the reparations the British Government in 1919 enacted what is now our section 41, or approximately the same, in order to prevent the issuance of patents on chemicals ---

THE CHAIRMAN: Does it follow then if a certain drug process is patentable in the United States and it is not patentable in Canada that the manufacturer in Canada may manufacture the same product with immunity? This would be a very serious matter.



THE CHAIRMAN: Just say section 41.

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THE CHAIRMAN: Does it follow then if

a certain drug process is patentable in the United States

and it is not patentable in Canada that the manufacturer

in Canada may manufacture the same product with impunity?



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MR. FORGET: That is correct.

THE CHAIRMAN: Well now, why do you say that it is detrimental to the public interest?

MR. FORGET: It is detrimental in two ways. It is obvious that I am not going to spend much money here in research if I know that upon my inventing something useful it will be copied by my competitor immediately and I might lose my investment.

If we believe in the patent system, which is a recompense for invention, obviously we discourage invention if we take the recompense away.

THE CHAIRMAN: All these arguments were made to the Illsley Commission?

MR. FORGET: Yes. Some of them, yes.

THE CHAIRMAN: And the Illsley Commission has reported?

MR. FORGET: That is correct.

THE CHAIRMAN: We have taken the view that we are not sitting in judgment on another Royal Commission that has dealt specifically with patents.

MR. FORGET: I am happy to hear that, Mr. Chairman, because the Illsley Commission recommended the repeal of such ---

THE CHAIRMAN: Whether they recommended or not, if that recommendation has been made the problem is before government in Parliament?

MR. FORGET: Yes. Is it not part of this Commission's terms of reference to review what effect the weakness of the drug patents may have on the availability of drugs in Canada from the point of



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My Committee was alarmed at the possibility that gradually all research in Canada would disappear instead of increase and that we will become increasingly dependent on foreign sources of supply which we think is a very dangerous position in which Canada might find itself and that is the point that we wanted to bring to your Commission's attention.

THE CHAIRMAN: We had two very important drugs. Penicillin was not patented?

MR. FORGET: That is correct.

THE CHAIRMAN: Now, has there been any lack of research in that field?

MR. FORGET: Penicillin was not patented. The original discovery of penicillin was not patented by Dr. Fleming but the Americans patented the method of making penicillin on a vast scale, a large commercial scale.

As a matter of fact, the British had to pay royalties to make penicillin to the United States because they had forgotten to patent penicillin in the first place. The Americans had not forgotten to patent the process of making it in large quantities.

THE CHAIRMAN: I do not follow you because if they did not have to patent it in England, their legislation is the same as ours, they could tell them to go jump in the lake.

MR. FORGET: But in the United States ---

THE CHAIRMAN: I am talking about in the

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MR. FORGETT: But in the United States --

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case of the home market.

MR. FORGET: In the home market there would be no process patent, I wouldn't think, but in the United States the British could not sell penicillin without paying royalties, whereas, the Americans could sell penicillin in the United Kingdom without royalties.

THE CHAIRMAN: Then, of course, we have insulin here in Toronto.

MR. FORGET: Insulin, of course, was patented.

THE CHAIRMAN: Insulin was patented and the rights turned over to the Institute.

MR. FORGET: To the University of Toronto, yes.

THE CHAIRMAN: There was no lack of research. These two very important drugs seem to have followed pretty well a parallel pattern. One not patented, one patented.

MR. FORGET: Penicillin was patented in the United States.

THE CHAIRMAN: The process was?

MR. FORGET: The process; and insulin was patented here and all over the world and the royalties have, of course, enabled the university to function and to continue research. It was an essential part of the success of insulin, this patent, otherwise everyone could have made insulin with impunity and nobody could have - no money could have been given to the University of Toronto or to the doctors who



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discovered it for continuing their research and recompens-
ing them for having discovered this.

COMMISSIONER VAN WART: I am somewhat
confused about your patents. You say that, first, in
the United States, the product was patented?

MR. FORGET: That is correct.

COMMISSIONER VAN WART: And in Canada
the process was patented, not the product?

MR. FORGET: If you have a chemical
process ---

COMMISSIONER VAN WART: It can be
patented?

MR. FORGET: If it doesn't result in
the drug - let me put it clearly. You have a drug.
If the drug is made by a chemical process the drug is
not patentable unless the chemical process is patentable.

In other words, if I use a conventional
chemical reaction like oxidization, and things that are
well-known, to create a new drug, I cannot patent that
new drug because my process is conventional.

THE CHAIRMAN: It's the same thing
you do with automobiles.

MR. FORGET: With an automobile, yes,
you can patent it, if you make a new automobile.

THE CHAIRMAN: You have to do something
novel to patent it.

MR. FORGET: If you make a new automo-
bile by conventional ways, you can patent the automobile,
not the way you make it. If you make a drug by conventional
chemical process, you cannot patent it.



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COMMISSIONER VAN WART: My confusion is this: if a drug - the product is patented in the United States. You come along and state that penicillin, the process was patented?

MR. FORGET: Penicillin itself was not patented, the drug, but the process for making it was patented.

COMMISSIONER VAN WART: In the United States?

MR. FORGET: In the United States, yes.

COMMISSIONER VAN WART: So evidently their patent laws cover both process and product?

MR. FORGET: Yes. Not our patent laws.

COMMISSIONER VAN WART: The United States.

MR. FORGET: In the United States a drug patent is like any other patent. There is no distinction between a drug patent and a patent for a fountain pen or an ash tray.

COMMISSIONER VAN WART: Both the process and the product?

MR. FORGET: Yes. We have a number of situations. If you have a new process to make an old product, you can patent the process. Obviously you cannot patent the product because it is old. If you have an old process to make a new product, you can patent the product. You have to have a new process to make a new product and patent both.

Now, that is the kind of thing you can get in Canada for drugs where your process is new and



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your drug is new. Both of them. If your process is new you cannot get your drug patent here, whereas in the United States and in England now, in France, in Australia, they changed the laws in the last few years in these countries. A drug patent is just like another patent. It's subject to the same conditions and there is no particular discrimination against it. There is no disability against a drug patent.

COMMISSIONER McCUTCHEON: Britain has retreated from the position it took in 1919?

MR. FORGET: Yes, in 1949 they retreated. We had followed the British example but there is a small difference between our Section 41 and the equivalent British section. It's a small difference that means much. I don't think I ought to burden the Committee with it.

THE CHAIRMAN: I think we understand your position.

MR. FORGET: Though I was dealing there with the weaknesses of the patent system based on Section 41, the impossibility of getting drug patents when the drug is produced, as most of them are, by conventional chemical process. The second disability, of course, is the compulsory licensing of drug patents. That is Section 41, sub-section 3. This is, again, a discrimination against the drug patents. If I have a drug patent I am pretty much at the mercy of my competitors who can come to me and demand that I licence them.

Of course, other patents are not subject to all these differences.

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Forget

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THE CHAIRMAN: Food and drugs.

MR. FORGET: Only food and drugs. Now, I mentioned before we are in favour of retaining Section 66 which makes all patents subject to compulsory licensing if the product is not available in Canada for Canadian sources on reasonable terms. We are in favour of that but I do not believe we should go beyond that and make the licensing of drugs compulsory in all cases as it is now.

THE CHAIRMAN: Is that statement quite correct? The decision in the Fine Chemical case ---

MR. FORGET: It is not 100% compulsory ---

THE CHAIRMAN: The restriction was you can only get compulsory licence to manufacture in Canada.

MR. FORGET: Yes. That was the decision but, of course, you are at the mercy, nevertheless, of any person who wishes to manufacture in Canada.

THE CHAIRMAN: The person must pay an appropriate royalty fee?

MR. FORGET: Yes, but even so ---

THE CHAIRMAN: Having regard to the cost.

MR. FORGET: How is the fee to be fixed? That is part of the debate. We, of course, would like Section 66 to remain and the fee to be fixed in accordance with the terms of this Section 66. We don't see the reason for another Section 41(3) which discriminates against drug patents, eliminates the safeguards of Section 66.

You see, in order to obtain a licence



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You see, in order to obtain a licence



Forget 12578

under Section 66 you must show that the product is not available in Canada from Canadian sources on reasonable terms.

THE CHAIRMAN: After three years.

MR. FORGET: After three years. Now, if the defendant, shall we call him that, shows that the Canadian demand is being met on reasonable terms from Canadian manufacturers then the licence is not issued.

In the drug field there is no defence, practically no defence. If the responsible manufacturer wishes to have a licence, he can get it immediately and there is no wait.

THE CHAIRMAN: I don't know, there seems to be a lot of litigation.

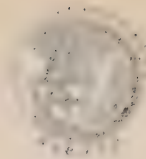
MR. FORGET: Well, not so much. What happens is, of course, the existence of Section 41(3) will provoke voluntary licensing.

If I know that I can be dragged before the Commissioner of Patents and forced to issue a licence, I might as well be a good loser, a good sport, and give the licence myself. Make a better deal, probably than I might get with the Commissioner.

THE CHAIRMAN: But the process has taken two or three years to get that decision from the Commissioner up to now.

MR. FORGET: It has taken time in some cases.

THE CHAIRMAN: So that you arrive by the slowness of the process back at Section 66.



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MR. FORGET: Well, except that if you can show they are making the drug available to Canada on reasonable prices you have no defence under Section 41(3). That is the main point. Your drug patent system does not mean very much if my competitors can come here and obtain a licence and take part of your market away. I am not very much interested in developing a drug in the first place.

THE CHAIRMAN: You have developed it not for the Canadian market. This compulsory business is practically all foreign patents, that are simply being registered in Canada.

MR. FORGET: The patent must be Canadian patent, of course, and they could be owned by anybody. Owned by the Canadian drug firm, American drug firm, or any drug firm but if that American firm, let's say, has a subsidiary here, employs people here, manufactures here and so forth, and supplies a Canadian market under the patent, why should a competitor come along and demand a licence and take half of his market away?

THE CHAIRMAN: Of course, you are aware that representations are being made to us that the Commissioner's decision is wrong and that Parliament ought to eliminate the restrictions that he put on up to date by saying you can only get a licence to manufacture in Canada but not to import into Canada.

MR. FORGET: That is right.

THE CHAIRMAN: Those representations are being made on the right of compulsory importation,

MR. FORGET: Well, except that if

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MR. FORGET: That is right.

THE CHAIRMAN: Those representations are being made on the right of compulsory importation,



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compulsory licensing, to permit importation.

MR. FORGET: I think that would be a very bad thing for the Canadian manufacturers. I would certainly say that the industry as a whole would say that, even that part of the industry which has foreign manufacture, because of the various factors I have mentioned before. If the imports come in from low-cost countries our manufacturing industry in the drug field is going to suffer very badly.

THE CHAIRMAN: But if the situation is as it has been represented, and this is not any formal statement, drug prices in Canada are sharpened, then some process by which the price, the cost, might be related to the consuming public might justify these unusual procedures.

MR. FORGET: If it were shown that the prices were exorbitant, I would say yes. Unfortunately, for those who have made those statements, I cannot see they are correct. We have discussed, and the brief will show the other side of the story, if I may call it that, loss of profit realized and all that sort of thing.

Now, I agree, if the public was being mulct by the drug industry, I would certainly agree with you.



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4 If you multiply the drug industry,
5 I would certainly agree with you that all barriers should
6 be lifted against foreign imports, but if it is shown
7 that the drug prices are reasonable and that the companies
8 are complying with Section 66 and so forth, I believe
9 that it is unfair to discriminate against them, and weaken
10 their operation to the point where they have little
incentive to manufacture in Canada.

11 That is the burden of the submission
12 I make. That is the second part, or second defect which
13 I see in our patent system as it relates to drugs.

14 There is another one, which is terribly
15 complex, but a real one too. A recent decision of the
16 Supreme Court in a case, I think the Commission of Patents
17 and Hoffman, LaRoche and in that case it seems that a
18 drug cannot be the subject of what is called a process
19 dependent product claim in a patent action unless the
20 drug is new. We have in Canada, as in England and various
21 other countries this theory, that where a process is
22 patented the product of the process, even if it is old,
23 is likewise patented, if it is made by the patented process.
24 In other words, if I invent a new method of making glass-
25 ware, and this glass is made by my method, and my method
26 is patented, this glass would be patented automatically.
It will be patented if it is made in accordance with the
patented process.

27 COMMISSIONER McCUTCHEON: But not other-
28 wise?

29 MR. FORGET: No. The consequence of
30 that is very interesting. It is this. Suppose I have a



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COMMISSIONER OF PATENTS: But not other-

MR. FORT: No. The consequence of

that is very interesting. In this, I suppose I have a



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patented process, in Spain, a competitor of mine can set up shop in Spain, use the process in Spain to make glasses, and then ship the glasses to Canada.

THE CHAIRMAN: Well, is that so?

MR. FORGET: I am coming to the point. I am just saying that if we don't have this theory, this glass made in Spain by my patented process is patented automatically. I couldn't stop the importation into Canada of the glass, but fortunately our theory is that a product made by a patented process is patented automatically, therefore, I can stop that man ----

THE CHAIRMAN: You can stop him from importing into Canada?

MR. FORGET: Yes.

COMMISSIONER McCUTCHEON: If the end product is patented.

MR. FORGET: The end product is patented automatically if made by the patented process.

It seems to me from that decision that in drugs at any rate those process dependent product claims would not be valid under Section 41 (1), and in order to get a process dependent product protection for a drug, the drug would have to be new, so if I found a new process to make aureomycin for example, my competitor could set up a shop in Spain, use my process, and flood my market with aureomycin made in Spain.

THE CHAIRMAN: Is that decided? I thought it was before the Court now?

MR. FORGET: It is before the Court still, but it is a very sensitive point with the drug



patented process, in Spain, a composition of wine can be
up and in Spain, use the process in Spain to make glasses
and then ship the glasses to Canada.

THE CHAIRMAN: Well, is that not?

MR. TONGUE: I am coming to the point.

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THE CHAIRMAN: You can ship this from

MR. TONGUE: Yes.

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in drugs at any rate those process dependent product claims
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the drug would have to be new, so I found a new process
to make amphetamine, for example, my competitor could set up
a shop in Spain, use my process, and flood my market with
amphetamine made in Spain.

THE CHAIRMAN: Is that decided? I

thought it was before the Court now?

MR. TONGUE: It is before the Court

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Forget 12583

manufacturers, because of course if some low-cost country manufactures this and shipments can be made to Canada and the patent will not stop them, they find themselves in a very awkward position.

At any rate, one of our recommendations is that the theory of the process dependent product protection be retained, or confirmed, in order to strengthen the patents for drugs as for anything else, and I think that would be the policy, a patent policy for Canada could aim at manufacturing and research in Canada, and hence should provide valid patent protection for drugs and foods, as well as for anything else.

I would retain, as I mentioned twice, Section 66 and so forth, because I think they give the public adequate protection, and I would note also Section 19 of the Act, which is a section enabling the Government to use any patent it chooses, on a royalty basis, of course, to the patentee, but it is obvious that if there were an emergency, and not enough manufacturing done in Canada, the Government could use that provision, without of course, the public being penalized by it.

COMMISSIONER McCUTCHEON: The Illsley Report recommended the repeal of Section 41 (1), but not of Section 41 (3).

MR. FORGET: That is correct, and I think the abolition also of process dependent product claims.

THE CHAIRMAN: Which you want?

MR. FORGET: Yes. Reading the Hoffman-LaRoche judgment, they have construed Section 41 (1) in



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MR. FORGET: Yes, keeping the Hoffman-

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Forget 12584

accordance with the early sections of the Act defining invention, precluding a process dependent product claim of a drug which is not new per se.

These are my submissions, Mr. Chairman.

COMMISSIONER VAN WART: You spoke of research in Canada. Is it not true that one of your companies in Montreal, associated with your submission, on the 1st of July is opening up a research department, transferring its American research to Canada?

MR. FORGET: I am not aware of that, sir. It is quite possible.

COMMISSIONER VAN WART: I understand the Ayerst McKenna people are opening up a laboratory in Montreal, and transferring their American research to Canada on the 1st of July.

MR. W.A. LESLIE: My name is Leslie and I am with Ayerst McKenna and Harrison. I would like to make the statement that we are in a very fortunate position. We are a Canadian company, started in 1925, and early in the 30's we started building research laboratories in Canada, and through the results of our research were able to open up in the American market in 1934.

We have continued through the years, and have had a lot of difficulty in retaining our research facilities in Canada, rather than in the United States after we became affiliated with American Home Products, but we have continued to do the majority of the research for the American company and other Ayerst subsidiaries around the world in Montreal.



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MR. ROBERT: I am not aware of that.

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COMMISSIONER VAN WART: I understand

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W.A.Leslie 12585

On many occasions they have suggested that it be taken out of Montreal and into the States, because there is more work to be done down there, some expenses could be saved, and so on, but we have retained that.

There is no new development in our operation. We have retained that research facility in Canada, because we are in that unique position of being able, having started here, we have been able to develop.

Now, there are two other folks in Canada that have developed research facilities. Charles E. Frosst and Frank W. Horner, which are smaller than our operation, because it is confined to the the Canadian market. There are a number of our friends in the pharmaceutical industry who would come into Canada and start research facilities here, also manufacturing what we call fine chemicals in the pharmaceutical industry, if this compulsory licence feature was not in The Patent Act, because it is a detriment to the full operation of research facilities here, and you have got no protection whatever. I mean, anybody can move in and get the compulsory licence. The very fact that it is there, it acts as an umbrella, and the patentee will hesitate to take legal action against an infringer, because there is no chance of stopping it if the Commissioner has given a compulsory licence, or the infringer wants to use the patented process to make a product, or have it made by somebody else in Canada for him, he can go ahead and do that without asking for a compulsory licence.

THE CHAIRMAN: Now, Mr. Leslie, I must



W.A. Leslie 12585

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market. There are a number of our friends in the pharmaceutical industry who would come into Canada and start research facilities here, also manufacturing what we call this chemical in the pharmaceutical industry,

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company. I mean, the very fact that it is there, it acts as an inhibitor, and the patented will result to take legal action against an infringer, because there is no chance of stopping it if the Commissioner has given a compulsory license, or the infringer wants to use

the patented process to make a product, or have it made by somebody else in Canada for him, he can go ahead and do that without asking for a compulsory license.

THE CHAIRMAN: Now, Mr. Leslie, I must



W.A. Leslie 12586

say that I cannot accept that. You can manufacture if you have got the licence. That is what the Act says.

MR. W.A. LESLIE: That is what the Act says, but what I am saying, Mr. Chairman --

THE CHAIRMAN: Therefore, if you don't feel inclined to take the legal remedies, to use the protection that the law gives you, what else can a patent Act give you?

MR. FORGET: But of course, the very existence of the section makes the question rather theoretical.

THE CHAIRMAN: No, it does not make it theoretical at all. It is just the same as if the City of Toronto has the right to take a building by expropriation, that they are going to take it without expropriating it. The underlying conditions must be complied with before you are entitled to a compulsory licence.

MR. LESLIE: Apparently I believe there are cases on the record of an infringer going on the market, infringing a patent, and then after he has been in the market, asking for a compulsory licence, and it was not detrimental to his possibility of getting that compulsory licence, because he had infringed the patent beforehand.

THE CHAIRMAN: All right, I mean, I just cannot accept the bald statement that you made, because it is not a correct statement of the effect of the Act.

MR. LESLIE: The machinery is there for us to take legal action. You are quite right, sir, but



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MR. LESLIE: The machinery is there
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Leslie 12587

it is not done for the simple reason that there is an umbrella there to protect the infringer.

THE CHAIRMAN: Thank you very much, Mr. Forget. These are matters of extreme importance, as we know. But there is this situation, that the field has already been canvassed by one Royal Commission. It has made its report, Parliament has not yet acted upon that report, and we could not, under our terms of reference, broad as they are, ever assume the right to sit in review on another Royal Commission.

MR. FORGET: I quite see the point, Mr. Chairman, but I just wanted to bring these matters to your attention.

THE CHAIRMAN: We had the submission from the Pharmaceutical Manufacturers' Association, a substantial submission, but I understood from them that they were doing a tremendous amount of research in Canada. That is what they stood up here and told us, that they were really doing a lot.

MR. FORGET: This is part of the program to support research in this country.

THE CHAIRMAN: They said they were doing it, and the notion that they weren't doing research in Canada was really a slander on them.

MR. FORGET: I don't know what figures they have, but mine don't corroborate them.

MR. LESLIE: I would like to see a lot more.

THE CHAIRMAN: Quite, undoubtedly.

MR. LESLIE: Since the question was



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asked about our position in Canada, I thought a copy of
that might be of use to you gentlemen, giving a short
history of Ayerst McKenna and Harrison, and the research
facilities they have.



asked about our politics in Canada, I thought a copy of
this might be of use to you gentlemen, giving a short
history of Avery Johnson and Harrison, and the reason
behind their name.

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4 THE SECRETARY: Mr. Chairman, the
5 next submission is from the Ontario Society of Oral
6 Surgeons, exhibit 386, and Dr. Van de Mark will introduce
7 his group and read the brief to the Commission.

8 ---EXHIBIT NO. 386: Submission of the Ontario
9 Society of Oral Surgeons.

10 SUBMISSION OF
11 THE ONTARIO SOCIETY OF ORAL SURGEONS

12
13 APPEARANCES: Dr. R.E. Diprose
14 Dr. J.H. Johnson
15 Dr. J. Methven
16 Dr. Van de Mark

17 DR. VAN DE MARK: Mr. Chairman, with
18 me I have Dr. John Methven, who is on the staff of the
19 University of Toronto, Department of Oral Surgery, and
20 is in private practice, and Dr. Joseph Johnson, on the
21 staff of the Faculty of Dentistry and Dr. Diprose also
22 on the staff of the Faculty of Dentistry and in private
23 practice. Dr. Antoni is absent. He was Chairman of
24 the group who got this brief together. He is unfortunately
25 in Vancouver. He is on the Board of Governors of the
26 C.D.A. there.

27 I will read the brief; it is very short.

28 This brief is presented on behalf of
29 the Ontario Society of Oral Surgeons of Ontario. We
30 are a voluntary body composed of the specializing Oral
Surgeons of Ontario who have been certified as such by
the Royal College of Dental Surgeons of Ontario.

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 Society of Oral Surgeons.

THE COMMISSION OF

THE ONTARIO SOCIETY OF ORAL SURGEONS

Dr. W. E. Johnson
 Dr. J. H. Johnson

APPEARANCES:

Dr. Van de Mark

Dr. Van de Mark, Chairman, with
 me I have Mr. John McEwen, who is on the staff of the
 University of Toronto, Department of Oral Surgery, and
 is in private practice, and Dr. Joseph Johnson, on the
 staff of the Faculty of Dentistry and Dr. Higgins also
 on the staff of the Faculty of Dentistry and in private
 practice. Dr. Arnold is absent. He was Chairman of
 the group who got this thing together. He is unfortunately
 in Vancouver. He is on the Board of Governors of the

I will read the brief; it is very short

This brief is presented on behalf of

the Ontario Society of Oral Surgeons of Ontario. We
 are a voluntary body composed of the specializing Oral
 Surgeons of Ontario who have been certified as such by
 the Royal College of Dental Surgeons of Ontario.



2. Reason for presenting this brief

a. To acquaint you with the recognized dental specialty of Oral Surgery, so that you may give it due consideration, in order that it may assume its proper place and established responsibility in any health scheme that may be devised.

b. To point out that specialists are necessary to the dental profession and to the public. They provide specialized services and are vital to research and teaching.

c. To point out that there is a serious shortage of trained and certified specialists in Dentistry and that their distribution is very disproportionate. There are 35 certified Oral Surgeons in Ontario, but 23 of these practise in Toronto.

d. To recommend that when amounts of Federal grants to universities are being determined, consideration be given to the needs of dental schools and teaching hospitals to establish, maintain and augment graduate educational programmes, to provide the academic qualifications necessary for graduate students proceeding to specialization.

3. What is Oral Surgery?

Oral Surgery is the oldest recognized specialty in Dentistry and has to do with the diagnosis and surgical and adjunctive treatment of all diseases, injuries and deformities of the human teeth, jaws and associated structures. It has the longest and most exacting graduate training programme of any of the dental specialties, requiring three years of graduate study beyond



Statement of Dr. Van de Mark

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- d. To recommend that when surveys of Federal grants to universities are being determined, consideration be given to the needs of dental schools and training hospitals to establish, maintain and augment research educational programmes, to provide the students with qualifications necessary for graduate students proceeding to specialization.
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3 graduation as a dentist. One year of this is devoted to
4 the study of basic sciences and two years of internship
5 in an approved oral surgery training programme. It is

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7 4. Why is it necessary to have Oral Surgery?

8 An increasing amount of Oral Surgery
9 is being performed in the hospital at the present time.
10 Extensive surgery in the oral cavity, such as is now
11 necessary for multiple extractions with subsequent
12 alveolectomy, excision of cysts and tumours, surgical
13 removal of impacted teeth, the treatment of jaw fractures,
14 the surgical correction of malformations of the jaws and
15 the surgical management of acute dental infections is
16 comparable in severity, morbidity and risk involved to
17 any other operation involving the head and neck or nose
and throat.

18 In addition, the increasing number of
19 patients in the older age groups presents the problem
20 of increased systemic conditions requiring more specialized
21 care, the general practitioner in Dentistry is not
22 sufficiently trained to render this specialized type
23 of service. There is substantial evidence that if
24 the quality of oral surgical services received by the
25 Canadian public is to be maintained and improved there
26 must be recognition that Dentistry is a health service
in fact as well as in theory.

27 5. Hospital Dental and Oral Surgical Services

28 Hospitals are experiencing a growing
29 acceptance as centres of health care and they are playing
30



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4 an ever increasing role in the total health programme
5 of the nation. Therefore, we recommend the establishment
6 of dental departments in all public general hospitals.

7 We submit that a properly organized
8 Oral Surgery Division, staffed by qualified Oral Surgeons,
9 should be an integral part of all major hospitals. This
10 is vital for the training of specialists in Oral Surgery
11 and to render the specialized care required by the public
12 in this field.

13 6. Insurance

14 We further submit that oral surgical
15 treatment, whether it is necessitated as a result of
16 accident or pathological processes is usually non-recurrent.
17 Impacted teeth do not grow back after they have been
18 surgically removed and fractures rarely happen more than
19 once to the same patient. For this reason we maintain
20 that insurance coverage for oral surgical benefits is
21 actuarially sound and should be included in all surgical
22 insurance plans, whether public or private.

23 We wish to point out that several
24 surgical insurance contracts are in force, which pay for
25 oral surgery only when performed by a physician. We
26 submit that this is absolutely wrong and discriminatory
27 and it interferes with our livelihood, and with the
28 patients' full freedom of choice of surgeon.

29 We vigorously urge that you recommend
30 that this unfortunate situation be corrected and that
oral surgical benefits should be a legal obligation in
all contracts and honoured, regardless of whether the



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We submit that a properly organized dental department should be an integral part of all major hospitals. This is vital for the training of specialists in Oral Surgery and for the care of the patient.

Insurance

We further submit that oral surgical treatment, whether it is necessitated as a result of accident or pathological processes is usually non-emergent. Unrelated to the fact that many cases have been surgically removed and fractures rarely happen more than once to the same patient. For this reason we maintain that insurance coverage for oral surgical benefits is substantially sound and should be included in all surgical insurance plans, whether public or private.

It is well to point out that general surgical insurance contracts are in force, which pay for oral surgery only when performed by a physician. We submit that this is absolutely wrong and discriminatory and it interferes with our livelihood, and with the patient's full freedom of choice of surgeon.

We vigorously urge that you recommend that this unfortunate situation be corrected and that oral surgical benefits should be a legal obligation in all contracts and honored, regardless of whether the



Van de Mark

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surgeon happens to be a physician or a dentist.

We have one small item we would like to add to this, and Dr. Methven will speak to it.

DR. METHVEN: Mr. Chairman, what I have to say has to do with anaesthesia in connection with oral surgery. We oral surgeons perform services for the patient which require anaesthesia, local or general, and there are many cases where a local anaesthetic isn't adequate to perform our particular type of service and this service we supply in our offices and dentists utilize this service. We feel it is to the advantage of the patient and the dentist to have such service available.

To date no private insurance scheme takes into account this need, and we feel that any overall dental health plan which may be set up should realize the need for this service and provisions should be made for supplying funds to pay for it.

COMMISSIONER VAN WART: Take an example of a fractured jaw, to illustrate. As an oral surgeon do you treat a fractured jaw in the hospital?

DR. VAN DE MARK: Yes, or in the office, depending on the severity of the fracture, the type of treatment needed.

COMMISSIONER VAN WART: In the hospital with the oral surgeon, dentist, is he allowed to go into the operating room to treat?

DR. VAN DE MARK: The training stated here of three years is actually the minimum training, and many have both degrees; I have myself both degrees.



Van de Mark

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3 It depends on the local level, the hospital in question,
4 and our definition of oral surgery might be broad to
5 anyone who is still thinking of 20 years ago when we
6 spoke of orthodontology and now our diagnosis much broader;
7 we must clarify our definition as much broader now.

8 But at the individual level they
9 decide what the oral surgeon is allowed to do. Oral
10 surgery is under the general department in most hospitals;
11 the oral surgeon must prove himself to the chief surgeon,
12 he may have to operate on the first few fractures of
13 the jaw with the chief of surgery, and whether he has
14 three years or eight years extra after dental school
15 he still expects to go out and prove himself to be able
16 to handle fractured jaws better than people without a
17 dental background. We feel very strongly that oral
18 surgery, deformities, fractures, we have to have a
19 dental background because of the occlusion problem.
20 Perhaps the surgeon cannot just get the bones to unite,
21 he has to have a physiologic good function result.

22 COMMISSIONER VAN WART: Are you allowed
23 you able to go into the operating room as a dentist?

24 DR. VAN DE MARK: Yes. I am on the
25 staff of several hospitals and I am in the operating
26 room.

27 THE CHAIRMAN: You don't have to be
28 an M.D. to do it?

29 DR. VAN DE MARK: No. But if a certain
30 hospital had a rule that an F.R.C.S. was necessary to
be in the operating room, then we would not be allowed.

COMMISSIONER VAN WART: If the dentist

It depends on the local level, the hospital in question, and our definition of oral surgery might be broad to anyone who is still thinking of 30 years ago when we spoke of orthodonty and now our diagnosis much broader; we must clarify our definition as much broader now. But at the individual level they

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4 or oral surgeon enters the operating room, is that
5 patient his or does he work under a surgeon of the
6 hospital?

7 DR. VAN DE MARK: This again is decided
8 at the local level. He will be operating on his own if
9 he has proved himself to the chief surgeon in the
10 hospital.

11 COMMISSIONER VAN WART: In his account,
12 say, to the Compensation Board, does the oral surgeon
13 render his account direct to the Compensation Board or
14 through a surgeon?

15 DR. VAN DE MARK: Directly to the
16 Compensation Board.

17 COMMISSIONER VAN WART: In the case
18 of a plan, does he render his account through a surgeon
19 or directly to the plan?

20 DR. VAN DE MARK: Through a general
21 surgeon.

22 COMMISSIONER VAN WART: In that hospital,
23 he goes in and operates in that hospital. I understood
24 you to say that the plans do not include dentists.

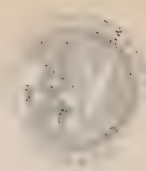
25 DR. VAN DE MARK: Certainly plans do not.

26 COMMISSIONER VAN WART: Can he recover
27 his fee through the surgeon in a hospital?

28 DR. VAN DE MARK: No, he can't.

29 THE CHAIRMAN: The Saskatchewan Act
30 provides for certain dental repair work following an
accident, but it must be done by a physician.

DR. VAN DE MARK: Is that so? This is
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Van de Mark 12222

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5 COMMISSIONER McCUTCHEON: He does it
6 without the benefit of an anaesthetic, though.

7 COMMISSIONER VAN WART: In the Blue
8 Shield Plan that is in operation in the Maritime Provinces,
9 in Newfoundland, for several years the
10 dentist couldn't recover his fee, he had to recover it
11 through the surgeon with whom he was associated, but
12 now he can recover his fee direct; they recognize the
dentist and the oral surgeon.

13 COMMISSIONER BALTZAN: Is certification
14 required in your specialty?

15 DR. VAN DE MARK: Yes, by the Royal
16 College of Dental Surgeons.

17 DR. JOHNSON: Gentlemen, there are one
18 or two comments I would like to make if you will bear
with me.

19 THE CHAIRMAN: Yes.

20 DR. JOHNSON: I am a dental teacher,
21 all my life I have been a dental teacher, and the whole
22 progress and the whole service to the public in the
23 future is naturally predicated upon what teaching is
24 going to be now and in the future.

25 I would like to refer to the brief
26 of the Canadian Dental Association, on page 9 of their
introduction, item 14. They say that "Federal and
27 Provincial income tax regulations be amended to permit
28 relief for dentists who attend training courses under
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3 associations." I think we would like to add our support
4 to that.

5 I would like to say a word for the
6 dental teachers. During my time, if you are going to be
7 a teacher you are supposed to be a leader and a researcher,
8 and if you are going to do that you must know what is
9 going on and if you are going to know what is going on
10 you must belong to societies and you must travel and go
11 to meetings. In my life I have spent \$500.00 a year in
12 membership in various scientific professional societies,
13 and I naturally don't attend all those meetings, because
14 I can't, but I have spent out of my own pocket at least
15 \$20,000.00, none of which is deductible for income tax.
16 The practising dentist can attend two scientific sessions
17 a year which are deductible for income tax, but for the
18 university teacher nothing is deductible, which I think
19 is most unfair.

20 But that is not the point I wish to
21 make. It is impeding and retarding dental teaching, and
22 I would hope you might see your way to recommend -- the
23 amount of money involved to the Treasury I don't think
24 would be very much, but it certainly would be of
25 tremendous assistance to the dental teachers and university
26 teachers, none of whom, I may say, have ever been
27 overpaid in the past.

28 The training of dental technicians,
29 the C.D.A. again said that the training of future dental
30 assistants and dental technicians be carried out using
clinical facilities at university dental schools, and
we would like most wholeheartedly to support that.



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5 submission from the Royal College of Dental Surgeons,
6 and these submissions have been on behalf of committees
7 and very conscientious, very hard-working committees,
8 but there is a diversity. The Royal College of Dental
9 Surgeons have told you that it is recommended that the
10 clinical facilities of university dental schools be
11 utilized in the training of dental technicians, which
12 I think everybody would be agreed to. But then they
13 also say it is a matter of considerable concern at this
14 time that there is no training program for it.
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But when they come to the training of dental technicians in No. R.19, training dental assistants, they say:

"It is recommended that training courses for dental assistants be established in Ontario in the science, technology and trades branch of the secondary education program and in vocational schools."

I am speaking personally now, but a large percentage of the profession, I think, would not agree with that. I do not think it is sound basically onologically; you cannot train a sailor without a sailor ever going to sea. They also have made a submission on the training of students in the use of dental assistants and I will quote it:

"It is recommended that the Faculty of Dentistry of the University of Toronto be provided with funds to engage a sufficient number of well-trained dental assistants to institute a program designed to teach dental students how to utilize the services of dental assistants most efficiently and effectively."

Where are we going to get these teachers? There is no program in Canada today except these little odd night courses, there is no organized night course for the training of dental assistants. For 40 years we ran the course at the Faculty of Dentistry

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4 at the University of Toronto for the training of dental
5 assistants but the source of those girls dried up because
6 the university required that they have the full Grade 13
7 standard. You know, a girl with Grade 13 standard will
8 not spend the time with the recompense she gets after
9 she has taken that training.

10 I would suggest that you might realize
11 that dentistry is a health service. I know, in one of
12 our western provinces, part of it has been put under
13 the Ministry of Labour but I do not think it belongs
14 there, I think it is a health service and this whole
15 thing should be tied in to one subject. I think the
16 dental assistants should be trained in our dental
17 schools and that each student, as he operates, should
18 be trained and the assistant trained at the same time.

19 The suggestion that has been made by
20 the Royal College of Dental Surgeons really puts the
21 assistant in the position of training the dentist
22 which, I think, is illogical.

23 Now, the hospitals train a variety of
24 technicians and our dental infirmaries in our dental
25 schools are equivalent to the hospital and if dentistry
26 were realized and recognized as a health service and
27 all these assistants and hygienists trained in the
28 dental school, they would be all part of one program.
29 They are all part of dentistry in different sections
30 but working towards the same thing.

Now, this educational barrier at the
present time, our program has been stopped because of
the educational barrier. A girl with Grade 13, she can



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3 take two years and be a hygienist; take four years and
4 be a high school teacher. A girl with that background
5 and training is not going to limit herself to that
6 extent. I hope that any recommendations you might make
7 that our dental infirmaries could be recognized as part
8 of that health scheme.

9 THE CHAIRMAN: Thank you very much,
10 Dr. Johnson. Are there any further comments?

11 DR. JOHNSON: Could I say one word to
12 get back to training, which is the beginning and end of
13 everything? In any health program that might be set up
14 the public ward patient has been the basis of the
15 training in both medicine and dentistry. I do not know
16 how it is now but with all these health plans and
17 social security it came to the time that the anatomy
18 departments were having a very difficult time finding
19 subjects to dissect. This does not affect us as
20 seriously as it does medicine but the ward patient has
21 been the source of training and if everyone is covered
22 by a health plan everyone is going to want the chief
23 of the service to operate on him and that is going to be
24 a real problem in oral surgery for the intern or the
25 resident to get proper training. That is one of the
26 possibilities.

27 At the present time, if a patient is
28 admitted to hospital with a fractured nose they are
29 covered by all plans practically but if they come in
30 a couple of inches below and have a fractured axilla
it is covered by relatively few plans unless it is done
by a physician.



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take two years and be a specialist; take four years and
be a high school teacher. A girl with that background
and training is not going to limit herself to that
extent. I hope that any recommendations you might make
that our dental institutions would be recognized as part
of that health scheme.

THE CHAIRMAN: Thank you very much.

Dr. Johnson, Are there any further comments?

Dr. JOHNSON: Would I say one word to
get back to training, which is the beginning and end of
everything? In any health program that might be set up
the public health aspect has been the basis of the
training in both medicine and dentistry. I do not know
how it is now but with all these health plans and
social security it came at the time that the anatomy
departments were having a very difficult time finding
subjects to dissect. This does not reflect on the
service as it does medicine but the ward patient has
been the source of training and if everyone is covered
by a health plan everyone is going to want the chief
of the service to operate on him and that is going to be
a real problem in oral surgery for the future. The
resident to get proper training. That is one of the
possibilities.

At the present time, if a patient is

admitted to hospital with a fractured neck they are
covered by all plans practically but if they come in
a couple of inches below and have a fractured skull
it is covered by relatively few plans unless it is done
by a physician.



Johnson

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In other words, the plan will pay the doctor for practising dentistry but will not pay the dentist for practising dentistry, which is not in the interests of the patient.

THE CHAIRMAN: You have made your point; we are aware of it and of the other situation that you have just mentioned. As I said before, we are grateful to you for having come with these ideas and I want to thank you for being here.



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Johnson

In other words, the plan will pay the doctor for practicing dentistry but will not pay the dentist for practicing dentistry, which is not in the interests of the patient.

THE CHAIRMAN: You have made your point; we are aware of it and of the other situation that you have just mentioned. As I said before, we are grateful to you for having come with these ideas and I want to thank you for being here.



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4 THE CHAIRMAN: There being no one else
5 present to make a submission the public hearings of
6 this Commission are accordingly at an end.

7 Since our preliminary meeting in
8 Ottawa on September 27th and 28th we have travelled
9 across Canada from one end to the other and in every
10 province. We have had the pleasure of hearing from
11 Provincial Governments as well as many other groups
12 and individuals who are part of the team or associated
13 with groups looking after the health and welfare of
14 Canadians.

15 We have received some 400 submissions
16 and I am told that they will run to some 12,000 pages
17 and some 3 million words so the volume has been very
18 considerable.

19 The views of the provinces and of those
20 concerned with health problems have been very ably
21 presented and carefully prepared submissions have been
22 received.

23 We still have to deal with the question
24 of rebuttal evidence. The Commission has decided that
25 all rebuttal evidence will be submitted in writing ini-
26 tially and those wishing to submit rebuttal evidence
27 will be required to file 25 copies of their submission
28 with Mr. Lafrance, the Commission Secretary, on or
29 before the 15th of September next. The rebuttal hearing
30 will be in Ottawa early in October, the date and actual
place of the hearing will be announced later. The
Secretary will then issue a schedule of appearances
for those who have filed submissions.



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4 Additional to that, I think I should
5 say that the Commission will accept supplementary
6 evidence at any time, in writing, from interested
7 parties but not for presentation at public hearings
8 unless by special arrangement.

9 I think it is very appropriate now
10 that we should place on record our thanks to the
11 secretarial staff for their valuable and devoted
12 service in the preparation and during the course of
13 these hearings and to express our thanks to them and
14 our confidence that in the completion of our work we
15 will have a continuation of the same type of service.

16 I want also to express our thanks to
17 the court reporting firm of Angus, Stonehouse and
18 Company Limited. These very hard-working reporters
19 have had to take down evidence from perhaps the fastest,
20 some of the fastest, talkers in the country and we
21 marvelled, at times, how they were able to do it. We
22 are grateful to them because they have worked unobtru-
23 sively and very efficiently.

24 I want, too, to express the thanks of
25 the Commission to the press for the very full and
26 favourable reporting on our hearings. The publicity
27 given has been of much value because without the co-opera-
28 tion of the press and other news media the importance of
29 the inquiry might well have been lost upon the public.
30 This publicity has pointed up the magnitude and complex
nature of the whole problem of health services and has
served, I think, to dispel the notion that some simple
solution or any one plan or program can be accepted

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ROYAL COMMISSION ON HEALTH SERVICES

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without very great study.

In closing our public hearings, I think we may repeat what we said at the very beginning; that we are fully conscious of the heavy responsibility placed on us by our terms of reference and we hope to carry out this responsibility to the best of our ability for the good of the whole of Canada and all its people.

The public hearings are, therefore, at an end and we enter upon our pertinent consideration and study, along with our research staff and consultants, from which many months hence a report will emerge.

Thank you very much.

--- Adjournment

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from which many months hence a report will emerge.

Thank you very much.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT
OTTAWA

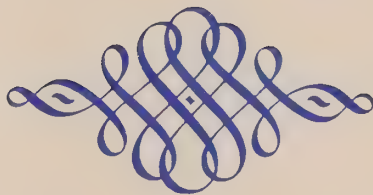
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4 ROYAL COMMISSION ON HEALTH SERVICES

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6 Proceedings of the hearings held
7 in Ottawa, Ontario, on the 16th
8 day of October, 1962

9
10 COMMISSION MEMBERS:

11
12 Chief Justice EMMETT M. HALL -- Chairman

13 Miss ALICE GIRARD, R. N.

14 Dr. C.L. STRACHAN

15 Dr. ARTHUR F. VAN WART

16 Mr. M. WALLACE McCUTCHEON, Q. C.

17 Prof. O. J. FIRESTONE

18 Dr. DAVID M. BALTZAN

19
20 COMMISSION COUNSEL:

21 Mr. R. N. HALL, Q. C.

22
23 MEDICAL CONSULTANT:

24 Dr. PIERRE JOBIN

25 DIRECTOR OF RESEARCH:

26 Prof. BERNARD BLISHEN

27
28 COMMISSION SECRETARY:

29 Mr. N. LAFRANCE
30



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VOLUME 67

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Ottawa, Ontario,
October 16, 1962.

---UPON COMMENCING AT 10:00 p.m.

THE SECRETARY: Mr. Chairman, before we start the rebuttal hearings of the Commission, I would like to file as Exhibit 381 a submission of the Province of Ontario, which was received by mail.

THE CHAIRMAN: That will be Exhibit No. 381 which was received some weeks ago and has been distributed to members of the Commission.

THE SECRETARY: That is correct sir.

THE CHAIRMAN: It is an extremely valuable document. It is the factual material that we had requested from the Province of Ontario, and we are very grateful to the Department of Health of Ontario for the preparation of this document containing the material that we needed. It will become part of the record as Exhibit No. 381.

---EXHIBIT No. 381: Submission by the Province of Ontario.

THE SECRETARY: Sir the first submission will be the Canadian Health Insurance Association. This will be Exhibit No. R-1, and an additional document which indicates some examples of plans will be marked as Exhibit No. R-1A.

---EXHIBIT No. R-1: Submission by the Canadian Health Insurance Association.

---EXHIBIT No. R-1A: Document indicating Example Plans



1 THE SECRETARY: Mr. Kilgour will present
2 the members of his group, and also speak to the submission.

3 MR. KILGOUR: Mr. Chairman, my name is
4 Kilgour. I am here as President of the Canadian Health
5 Insurance Association. I have with me Dr. J. C. Emmett,
6 Medical Director of the Imperial Life Assurance Company
7 of Canada. On the extreme left is Mr. C. N. Watson,
8 Group Vice-President, The Crown Life Insurance Company.
9 On my right Mr. G. R. Berry, Vice-President and General
10 Manager, Metropolitan Life Insurance Company. Second
11 from the left, Mr. R. R. Story, General Manager of the
12 Continental Casualty Company. On my extreme right Mr.
13 R. H. Reid, President and Managing Director, The London
14 Life Insurance Company and Mr. Corbet L. Drewry, Managing
15 Director of our Association. These gentlemen will assist
16 in answering any questions that may be asked by the
17 Commission.

18 Our appearance here today is based on the
19 request of your commission that we suggest some techniques
20 whereby Government could assist people in the lowest in-
21 come groups to finance their health care expenses. This
22 we have tried to do in a manner that does not intrude into
23 the lives and freedom of the vast majority of self-
24 supporting Canadians.

25 May I reiterate our view that Government
26 participation should be confined to the truly needy and
27 that we have proposed measures whereby adequate health
28 insurance can be made to every Canadian who wants it,
29 with those who can pay for it doing so at no expense
30 to government. Those who are identified as needy will
be given government assistance on a sliding scale through
our existing tax machinery.

Our submission today is not a recommenda-
tion, but it does suggest a middle ground between the
spectre of compulsory medical care for all as launched
by Saskatchewan and the status quo.



SUBMISSION OF THE CANADIAN HEALTH INSURANCE ASSOCIATION

APPEARANCES:

Mr. D. E. Kilgour,	Dr. J.C. Emmett,
Mr. C. N. Watson,	Mr. G. R. Berry,
Mr. R. R. Story,	Mr. R.H. Reid
Mr. Corbet L. Drewry.	

SECTION A

SUMMARY

1. This submission, prepared by the Canadian Health Insurance Association, is supplementary to our main submission filed with the Royal Commission on Health Services April 17, 1962, and discussed at the Commission's public hearings in Toronto, May 16, 1962.

2. Our purpose in filing this supplementary evidence is three-fold:

(1) to comply with the request of the Royal Commission made to the Association at the public hearings in Toronto last May that the Association put forward some specific suggestions* regarding the methods and procedures which might be involved in extending the health insurance coverage provided by the Association's illustrative plan to those financially unable to pay the premium required. It should be understood that the suggestions contained in this submission represent but one way of accomplishing this end,

*See Pages 10298-99-300 Transcript Toronto Public Hearings May 16, 1962.



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(2) to explain in greater detail than was done in the main submission the reasons why provincial legislation is necessary to implement the Association's proposals; to review a number of the significant developments which have occurred since our appearance before the Commission last May and to indicate the scope and direction of the Association's activities for the immediate future, and

(3) finally, by restating the purpose, role and benefits of voluntary health insurance, to answer some of the criticisms of, and comments on, the voluntary system made both before the Commission and elsewhere.

3. That we, as insurers, have a great interest in the preservation of the voluntary system of health insurance, there can be no doubt, nor do we make any apology for our efforts to preserve and improve upon this system. We earnestly believe that the health needs of Canadians can best and most efficiently be paid for through the voluntary system of health insurance without imposing a heavy, continuing and unpredictable burden on the country's already strained financial resources.

4. We fully recognize that there are, and always will be those who, for reasons beyond their control, will be unable to pay for their own medical requirements. For these, society must assume the responsibility to ensure that no Canadian suffer for



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4 want of necessary medical care and, in meeting this
5 responsibility, must also ensure that the means, in
6 terms of medical practitioners, nurses, hospitals and
7 other facilities, are available. We are firmly con-
8 vinced, however, that it would be wasteful of our
9 national financial resources, to say nothing of imposing
10 a critical and unnecessary strain on the available
11 services, for the government to assume the responsi-
12 bility for paying the entire medical bills of the vast
13 majority of Canadians who, with their own resources or
14 by means of health insurance coverage, are able to
15 pay their own way.

5. The Canadian Welfare Council, in its sub-
16 mission to this Commission last May stated that whatever
17 approach is taken to this problem... "High priority
18 should be given to those services which a considerable
19 portion of the population frequently requires and of
20 which the cost to the individual or family can be
21 relatively burdensome. One example is medical care".
22 With this we agree and we believe that this aim can
23 most effectively be achieved by the individual budgeting
24 the relatively small amounts required to provide him-
25 self and his family with health insurance through which
26 the bulk of the important medical costs that most
27 frequently occur can be paid.

6. In this submission, we shall attempt to
28 cover both the philosophy and practical application of
29 our views. We believe that this may be helpful, not
30 only to allay any misapprehensions as to the nature and
function of the voluntary system, but also to make



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possible a fair and accurate appraisal of the worth
and benefits of voluntary health insurance and its
important part in the over-all picture of providing
health care to Canadians.

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THE MEDICALLY INDIGENT
---A SUGGESTED FORMULA FOR
PROVIDING COVERAGE FOR THIS CATEGORY

7. The Canadian Health Insurance Association, both in its preliminary submission in Halifax and again in the main submission in Toronto, stated that it was "very well aware that some segments of the population are not in a financial position to pay even a most reasonable premium for voluntary medical insurance. Such persons will continue to require financial assistance from governments or others; it believes, however, that it is unrealistic and unnecessary to institute overall, compulsory, government-sponsored plans applicable to the entire population just to care for this relatively limited group. We stand ready to help solve this problem".

8. At the request of the Commission on May 16, the Canadian Health Insurance Association has undertaken to study this problem. In the months since the Toronto hearings, the Association and its member companies have discussed and considered the problem of providing coverage for the medically indigent class ---the truly indigent being cared for by private welfare agencies and the three levels of government. In presenting its proposals, the Association realizes that its approach is but one of a number possible toward the solution of the problem. It is however, in our opinion, one of the least complicated and most efficient methods in that it makes use of the existing income tax mechanism without requiring widespread



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reorganization of available facilities or the creation of extensive and costly administrative machinery.

9. The problem divides itself into three main elements:

(1) the identification of the medically indigent group.

(2) the amount of the subsidy required from government.

(3) the mechanics of making the subsidy available.

IDENTIFICATION OF THE MEDICALLY INDIGENT GROUP

10. The medically indigent may be defined as that group which, as long as no misfortune befalls it, is capable of providing for its own normal needs but which, in the event of accident or illness, requires outside financial help to meet the costs of treatment. To determine the size and make-up of this group with any great degree of precision is extremely difficult, if not impossible. It would be reasonable, however, to suppose that any individual* (and his dependents) who is required to pay income tax should not be considered medically indigent. The government's decision that his income is adequate to contribute directly to the cost of government on an "ability-to-pay" premise is a contradiction of indigence. Conversely, however, if an individual's income is below the taxable level,

*"Individual" would require a suitable definition.



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it may be argued that in varying degrees there are narrow margins over and above those required for the necessities of life. Even amongst this group there are large numbers who would not be eligible for subsidy, for example, employees covered under employer-employee benefit plans and those whose medical care is already otherwise paid for by federal and provincial government schemes.

11. This approach to the problem incorporates a number of obvious advantages:

- (1) Some allowance is automatically made for the size of the individual family since the income tax exemption is larger for individuals with larger dependent families.
- (2) An automatic adjustment is made with respect to the aged because they are allowed a larger income tax exemption.
- (3) Inasmuch as some 80 per cent of the population is already income tested through existing legislation, the identification of the medically indigent group by this means would not involve the application of a means test.
- (4) Qualification for subsidy can quickly and easily be determined by making use of the machinery which is already in existence. The procedure which the individual must go through to receive a subsidy is no more than that required of



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taxpaying Canadians.

THE AMOUNT OF THE SUBSIDY

12. It should be made clear that under a plan of the type we propose, the carriers do not seek or want subsidies of any kind. In discussing the amount and type of the subsidy which might be provided, two points must be considered.

(1) The government subsidy ought to be to the individual and not to the provider of the insurance coverage. It then becomes a matter for the individual to determine whether he is eligible for the subsidy and to make the necessary application to receive it.

(2) Although the amount of the subsidy may range from a nominal percentage to as high as 100 per cent of the premium required, it is assumed that the cost of this subsidy would be shared in some way by the various levels of government. This division of the total subsidy, of course, is a matter for negotiation between the governments and is an area to be explored by governments and not the insurers.

13. Various public assistance programs are now providing medical care for certain groups of the population. To the extent that these programs are



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continued, their beneficiaries should not be eligible for the proposed subsidy.

14. The amount of the subsidy could be in accordance with a table depending upon the income of the individual as illustrated below.

Income* expressed as a percentage of income tax exemptions	Amount of subsidy expressed as a percentage of required insurance premium.
--	--

80 - 100%	25%
65 - 79%	50%
50 - 64%	75%
Less than 50%	100%

The subsidy would extend to the premium for the entire family in the cases where the head of the family qualified, provided no individual member of the family was required to pay an income tax. Where a member of that family was required to pay an income tax, that member would be excluded for the purpose of determining the subsidy.

* "Income" would be suitably defined as far as practical in accordance with the concepts of the Income Tax Act but could include transfer payments such as veterans' allowances, workmen's compensation and unemployment insurance payments.



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MECHANICS OF MAKING THE SUBSIDY AVAILABLE

15. An individual, by submitting his regular income tax form to the Federal Income Tax Department to demonstrate his eligibility for it, may apply for the subsidy applicable to him that year. The application for subsidy would be required each taxation year.

16. It should be understood that individual initiative would be required in order to apply for the subsidy and some might decide not to apply. The essential point is that the subsidy would be available and hence the insurance also.

17. The individual, having applied to and been approved by the Income Tax Department would receive a voucher. He would then be in a position to maintain an individual or family contract of one of the two types outlined in the Association's main submission or any other form of health insurance coverage determined to be eligible for this purpose. He would use the voucher to pay all or part of the required premium, supplying, where necessary, the balance in cash. The insurer would then issue the policy and reimburse itself for the subsidized portion of the premium by presenting the voucher to the government. The coverage could be purchased from any carrier of health insurance selling individual or family policies including service plans and other private plans as well as the licenced companies.



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S E C T I O N C

REVIEW OF EVENTS SINCE MAY 16
AND HIGHLIGHTS OF ASSOCIATION
ACTIVITIES SINCE THEN AND IN
THE IMMEDIATE FUTURE

18. Since our appearance before the Royal Commission on May 16 last, the members of the Canadian Health Insurance Association have worked diligently towards adapting the voluntary health insurance mechanism to enable them to extend coverage to all Canadians.

19. The implementation of a plan such as the one proposed by the Association, entailing as it does the pooling of effort and resources of all providers of voluntary health insurance, requires that working conditions be set out to ensure its successful operation.

20. High on the list of necessary prerequisites of the Association plan is the provision of provincial legislation to guarantee that the costs of providing the coverage we propose are equitably shared among all providers of voluntary health insurance. It is evident from the transcript of our appearance at the May public hearings that one phase of the Association's proposals which may not have been sufficiently explained was the proposal that provincial legislation was needed. Accordingly it seems desirable to expand upon the explanations given on this point in the main submission. In the first place, it should be noted that the Association's proposals contemplate no legislative or



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other compulsion or restriction on any Canadian. The only compulsion envisaged is that to be applied on the insurance carrier. So far as the individual Canadian is concerned, he will continue to be free to buy or not to buy as little or as much health insurance as he pleases. In this respect the Association's ideas are in marked contrast to those which have been submitted to the Commission by other groups which advocate various forms of compulsion on the individual.

21. Our plan calls for the establishment of a central reinsurance agency or agencies* through which the excess medical care costs of those people insured at the maximum premium can equitably be shared. If some insurers provided coverage to all who applied for it, regardless of age, sex, health or occupation of the applicant, at a premium which could not exceed a statutory maximum, while others retained the right to underwrite each individual risk, declining some and rating up others, the insurers providing the former coverage would soon be faced with a very adverse selection against them and would soon be priced out of the health insurance field. That is to say that everyone who could not qualify for the standard premiums available to healthy lives would flock to the providers of the unrestricted coverage. It is therefore obvious that legislation is necessary to guarantee that everyone suffering medical insurance, whether the organization is an insurance company, pre-paid plan, cooperative or

* Page 7, Section A, Paragraph 1.(4) main submission.
Pages 10254-5 Transcript, Public Hearing, Toronto, May 16.



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other carrier, must share in the losses incurred in the central reinsurance agency. Such legislation will create a permanent mechanism whereby it will be possible to equitably spread amongst all medical care policy-holders the added costs that will arise from insuring those people in bad health, and at advanced ages at the time when the policies are issued. To ensure the widest availability of this coverage, the legislation will require all carriers in the individual and family field to offer it.

22. A special committee of the legal counsel of the Association's member companies has drawn up a preliminary draft of the type of legislation required to meet these circumstances. This draft is currently being studied and refined by the committee.

23. In British Columbia, the Association has engaged in detailed discussions with the British Columbia Medical Association and Service plans and we anticipate that we shall soon be able to implement a voluntary health insurance plan comparable to the one proposed in our main submission.

24. The Association has also been engaged in a series of discussions with the Canadian Medical Association, and Trans-Canada Medical Plans to facilitate cooperation between the doctor-sponsored plans and the insurance companies in working out satisfactory adaptations of the proposed plan.

25. From the above it can be seen that the Association and its members have made, and are continuing to make, every effort to ensure that they will



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be able to implement either the plan proposed by the Association in its main submission or some plan comparable to it and so make broad health insurance coverage available to all Canadians.

26. Other developments may be mentioned. Last June, within two weeks of our appearance before the Commission, one of our member companies* introduced a medical-surgical insurance plan which it offered to all residents of Ontario without regard to their age, sex, occupation or condition of health. This plan was offered on a mass-enrolment basis with limited enrolment periods. We believe that a full description of the plan has already been filed with the Commission. Another company* has recently introduced a new health insurance plan designed to meet the needs of individuals and husbands and wives over 65 years of age. The plan includes hospital and nursing-home care benefits and medical, surgical and nursing benefits.

* The names of the companies will be supplied on request.



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SECTION D

PURPOSE, ROLE AND BENEFITS
OF VOLUNTARY HEALTH INSURANCE
--- A RESTATEMENT

27. Health insurance, properly defined, is a mechanism designed to protect the insured against the possibility of serious financial hardship arising from the cost of treatment of disabilities due to accident and/or illness, through the payment of regular, budgetable premiums.

28. Proponents of the voluntary health insurance system are not infrequently charged with the "failure" of the system to involve itself in undertaking to guarantee the provision of adequate, qualified medical services and facilities. Far from being a liability, we maintain, this is an asset --- a matter of knowing in what field our competence lies and of restricting our activities to that field. The guarantee of medical care involves control of the profession. In our judgment neither the insurance companies nor the government should have such control.

29. While the provision of sufficient well-qualified doctors, up-to-date hospitals, trained and efficient allied medical personnel, medical research and educational facilities, rehabilitation and preventive medicine services, is of major importance to the health of Canadians, such provision is not the responsibility of health insurance carriers.

30. These are quite properly the responsibility of the medical and allied professions and the



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other providers of these services including the federal, provincial and municipal governments. Any criticism of the voluntary insurance mechanism which falls into these categories is, quite obviously, misdirected and invalid. Health Insurance, in fulfilling its defined function of financing health care on a pre-payment basis, should by its flexibility, afford the fullest opportunity for continuing development of medical services on the highest plane. It should not, however, undertake the responsibility of intruding in or directing that development.

31. Continuing along the same line, opponents of the extension of voluntary insurance on a nationwide basis along the lines of the plan proposed in our main submission last May, have argued that the financial records of the private plans are not "amenable" to public scrutiny or control. This is not so. The insurance companies are under the close scrutiny and control of the Federal Superintendent of Insurance and the 10 Provincial Superintendents of Insurance with whom they must file detailed and complete annual statements. The implication that this alleged lack of public scrutiny or control could permit the acquisition of undue profits at the expense of the policyholders, is also refuted in the statement of K.R. MacGregor, the Superintendent of Insurance for Canada. In his annual report to the Minister of Finance in 1960, he commented on the earning power of health insurance as an investment. He said in part: "Such business (health insurance) at least on a group



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basis, has not proved to very profitable to life insurance companies and the chance of any return to life insurance policyholders.....seems remote".

32. Many of the commercial insurance companies are mutual companies owned by their policyholders. Profits realized by these companies in their operations are returned to the policyholders in the form of cash dividends or as credits against future premiums. Stock companies also make available most of their profits in the form of dividends to participating policyholders. By law their books are open for inspection by the Federal Superintendent who publishes very complete financial reports annually on the operation of all insurance coming under his jurisdiction. In practice, companies publish annual reports and make them available to their policyholders. Many, in fact, invite policyholders' inquiries in this matter.

33. The doctor-sponsored health insurance plans and other health insurance associations are required by law to file annual financial statements with the appropriate provincial department of insurance not later than four months after the end of the fiscal year. They are additionally required to furnish copies of this statement to subscribers on request.

34. Conversely, there is little public realization of the real cost of compulsory, government-sponsored schemes, where all or a large part of the cost is paid from the government's general tax revenue. "Premiums", where such are required, are in reality



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nothing more than compulsory contributions or taxes, covering only a small part of the cost of the plan. Because the payment of even these "premiums" is politically unpopular, the trend in the various provincial hospitalization plans appears to be in the direction of abolishing them completely and taking the entire cost of the plan out of general tax revenue, thus obscuring the real cost of the coverage.

35. From this it can be seen that the public is actually in a stronger position to accurately evaluate the financial position and affairs of the private insurers than it is to determine the real cost of a governmental "insurance" scheme. Knowing the exact cost of the services provided by the private insurers, the public may then indicate its acceptance or rejection of the practices of any private insurer in the sternest of courts --- the marketplace. The argument that more effective inspection and control can be exercised over a compulsory, government scheme through the ballot boxes is a specious for a number of reasons, not the least of which being that the public is ignorant of the actual cost of the plan it is supposed to be controlling. In addition, as a compulsory health plan is rarely more than one of a number of planks of a party's platform, a vote for or against that party is not necessarily a reliable indication of the voter's acceptance or rejection of any government health scheme plank. A vote for or against a party proposing a compulsory health scheme could be influenced by the voter's acceptance or



rejection of the platform as a whole. In short, the voter is rarely asked to decide on the single question of a health scheme but on a "package" platform which may include a health scheme plank.

36. We would like at this point to comment on certain other frequently made criticisms of the voluntary system of health insurance.

37. It has been stated by opponents of the voluntary system that the freedom of the individual employee in a group insurance plan, in which he has no option to change the type, benefits or premium of the plan, is as restricted as it would be under a compulsory, government-sponsored plan. This, of course, is an incorrect statement. In the first instance both the employees and the employer have a wide choice of competing plans to choose from. Having chosen the insurer, they then have a wide choice of options in the selected insurer's portfolio. Moreover, changes can be and frequently are effected at the request of the employer and employees after the contract is signed and in effect. Group contracts, as a general rule require a minimum of 75 per cent participation, thus allowing up to 25 per cent of the group to opt out entirely. Those who do so make no contributions to the plan and are free to select any of the many other individual and family plans on the market, or if they so desire, reject all forms of health insurance coverage. No such flexibility is present in compulsory government health schemes. Under these, the individual is presented with a single plan with



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rigid benefit and premium structures which he is compelled to accept, or at least to pay for. Also, in most cases, the existence of a government plan prohibits the existence of any alternate coverage offering similar benefits.

38. Another oft repeated statement is that there should be but one prerequisite for medical care --- the need for it. We are in complete agreement with this statement and believe that it accurately describes the situation in Canada today. We submit that needed medical treatment is available to everyone whether or not they have the means to pay for it themselves. This care is provided by the medical profession through its free treatment of the needy; through the welfare agencies of the three levels of government and through private welfare organizations. The implication of the statement, however, is that there should be no means testing of anyone requiring medical care. Taking this argument to its logical conclusion, it would be equally, if not more valid to say that evidence of need of food, clothing and shelter, certainly more basic necessities than medical care, should be sufficient for them to be provided by the state. Using this test the entire population of the country would have little difficulty providing evidence of these needs and the government could take over completely, providing "free" food, clothing and shelter for all Canadians.

39. In its own field, that of financing health services for Canadians, we emphasize that



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voluntary insurance is providing broad and comprehensive benefits which, in the overwhelming majority of cases* is fulfilling its function of relieving the individual or family of the cost of ill health.

40. Despite comments which deprecate this service, we submit that coverage of better than 50 per cent of all Canadians on a purely voluntary basis at the present time and the growth potential inherent in our proposed plan to extend this coverage to all Canadians is a major accomplishment and not one lightly to be regarded. In Section C of our main submission we outlined the extensive coverage and rapid growth of voluntary health insurance in Canada. This, we feel, is eloquent testimony to the trust and confidence the Canadian public has in our ability to provide the protection they desire.

41. Since our appearance before the Commission last May, one province -- Saskatchewan -- has adopted a universal compulsory medical care plan. Within a year or two at the most, the wisdom or error of that course will be revealed. It will then be possible to measure the quality of medical care, the comparative cost and the public's reaction to a compulsory plan operating in a continent otherwise pursuing the voluntary system. The Saskatchewan experiment was a large and explosive one and one whose results other governments, if they are prudent, will await and assess before embarking on a similar course. If governments

* See Main Submission Appendix IV, pp 1 to 24.

voluntary insurance is providing broad and comprehensive benefits which is the overwhelming majority of cases in fulfilling the function of relieving the individual or family of the cost of ill health.

However, we submit that coverage of better than 50 per cent of all Canadians on a purely voluntary basis at the present time and the growth potential inherent in our proposed plan to extend this coverage to all

Canadians is a major accomplishment and not one likely to be regarded as a decision of our main submission.

We are not faced with the extensive coverage of health care of voluntary health insurance in Canada. This, as

well, is a direct testimony to the fact that the Canadian public is in our country to provide the

protection they desire.

There are a number of points in the Commission's report which are of interest to the public.

First, the Commission states that the public is not satisfied with the present state of health care in Canada. This is a fact which will be reflected in the Commission's recommendations.

Second, the Commission states that the public is not satisfied with the present state of health care in Canada. This is a fact which will be reflected in the Commission's recommendations.

Third, the Commission states that the public is not satisfied with the present state of health care in Canada. This is a fact which will be reflected in the Commission's recommendations.

Fourth, the Commission states that the public is not satisfied with the present state of health care in Canada. This is a fact which will be reflected in the Commission's recommendations.

Fifth, the Commission states that the public is not satisfied with the present state of health care in Canada. This is a fact which will be reflected in the Commission's recommendations.



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in the meantime will face up to their first problem --- that of providing assistance for those unable to pay even the most modest premium for their medical care --- the problem insoluble by private initiative will be removed.

42. The growth and vigour of our industry in covering Canadians who can pay has already been demonstrated but it has recently been hampered by talk of compulsory government schemes. Given the power climate of personal responsibility and freed of the overshadowing possibility of government intervention, this growth and vigour will be accelerated to the point where virtually all Canadians who need and want coverage will have it.

43. The financing of medical care for the Canadian people deserves a dynamic atmosphere quickly susceptible to constructive change and progress. No one company, no government can provide this. The marketplace can.



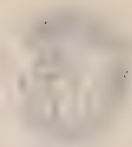
APPENDIX I

CORRECTION OF ERRORS
IN TRANSCRIPT OF MAY 16, 1962
TORONTO PUBLIC HEARINGS

- Page 10241 - Line 26 --- Change "at least projected" to "best effort at an objective".
- Page 10242 - Line 21 --- Change last phrase to read "and not only higher cost, but lower service".
- Line 24 --- Change "of our" to "and".
- Page 10243 - Line 12 --- Change "involved" to "Involves".
- Page 10244 - Line 4 --- Insert the word "more" before the word "concerned".
- Line 5 --- Put a period after "grandchildren". Strike out the word "that" and capitalize the word "The".
- Line 6 -- Change "grown" to "grew".
- Page 10245 - Line 10 --- Start a new sentence with "As Mr. Reid".
- Line 18 --- Change "state" to "see".
- Line 21 --- Change "10%" to "50%".
- Page 10260 - Line 15 --- Change "he" to "we".
- Line 17 --- Change phrase to read "to a specialist and not pay the extra fee at all otherwise".
- Line 20 --- Change "doctor" to "doctors".
- Line 22 --- Change "and" to "to".
- Line 25 --- Insert the word "than" after the word "less".
- Line 30 --- Replace the word "premium" with the words "extra cost in all cases".
- Page 10262 - Lines 11, 12 & 26 --- Change "physical" to "surgical".
- Page 10263 - Line 11 --- Change "qualify" to "clarify".



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3 Page 10264 - Line 5 --- Change "our" to "or".
4 - Line 16 --- Insert the word "department"
5 between the words "insurance" and
"actuaries".
6 Page 10269 - Line 3 --- Change "the" to "a".
7 Page 10271 - Line 10 --- Insert the word "if" in front of
the word "that".
8 Page 10281 - Line 28 --- Change "people" to "various
parties".
9 Page 10282 - Line 18 --- Change the last phrase to read
10 "any need to cover these in a
prepayment".
11 - Line 24 --- Change "extra" to "extras".
12 - Line 25 --- Change "as" to "if".
13 - Line 27 --- Change "to" to "who".
14 Page 10284 - Line 13 --- Change "raised" to "reached".
15 - Line 23 --- Change "would" to "which".
16 Page 10285 - Line 7 --- Change "family" to "voluntary".
17 Page 10287 - Line 5 --- Change to read "The average for
children would" striking out
"still".
18 - Line 24 --- Add at the end "would be sub-
standard".
19 - Lines 23
20 and 24 --- Delete sentence and substitute
21 "it would be a rare family where
more than one individual would be
substandard".
22 Page 10295 - Line 29 --- Change "having" to "leaving".
23 Page 10309 - Line 4 --- Change "come" to "comes".
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Line 1 - Change "to" to "or".

Line 17 - Change the word "Department" to "Bureau" and the words "Department" and "Bureau" to "Bureau".

Line 19 - Change the word "Bureau" to "Department".

Line 23 - Change the word "Bureau" to "Department".

Line 25 - Change the word "Bureau" to "Department".

Line 26 - Change "Bureau" to "Department".

Line 27 - Change "Bureau" to "Department".

Line 28 - Change "Bureau" to "Department".

Line 32 - Change "Bureau" to "Department".

Line 33 - Change "Bureau" to "Department".

Line 34 - Change "Bureau" to "Department".

Line 35 - Change "Bureau" to "Department".

Line 36 - Change "Bureau" to "Department".

Line 37

Line 38 - Change "Bureau" to "Department".

Line 39 - Change "Bureau" to "Department".

Line

Page 10295

Page 10296



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Mr. Chairman, our submission is a supplementary submission and has, I believe, been circulated and I would hope members of the Commission have had an opportunity to read it. It might be helpful if I made reference to one or two of the main points.

On page 1 we point out that our purpose in filing this supplementary evidence is three-fold:

- (1) "to comply with the request of the Royal Commission made to the Association at the public hearings in Toronto last May that the Association put forward some specific suggestions* regarding the methods and procedures which might be involved in extending the health insurance coverage provided by the Association's illustrative plan to those financially unable to pay the premium required."

I draw your attention to the point that we make at the middle of section 4.

"We are firmly convinced, however, that it would be wasteful of our national financial resources, to say nothing of imposing a critical and unnecessary strain on the available services, for the government to assume the responsibility for paying the entire medical bills of the vast majority of Canadians who, with their own resources or by means of health insurance coverage, are able to pay their own way."

*See pages 10298-99-300 Transcript Toronto Public Hearings May 16, 1962.



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May I ask those who are following the report to turn to page 4, and I would make this point:

"In presenting its proposals, the Association realizes that its approach is but one of a number possible toward the solution of the problem. It is however, in our opinion, one of the least complicated and most efficient methods in that it makes use of the existing income tax mechanism without requiring widespread reorganization of available facilities or the creation of extensive and costly administrative machinery."

Eighty per cent of the public are people who are now being income tested through the various government machineries.

Then on the top of page 5, section 9:

"The problem divides itself into three elements:

- (1) the identification of the medically indigent group. "

This is one section of our report.

- "(2) the amount of the subsidy required from government.

- (3) the mechanics of making the subsidy available."

This is developed in the body of the submission.

And then Mr. Chairman, I would like to draw your attention to the fact that we have also on page 9, we have further developed our proposals. That is



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4 additionally to those submitted in our May submission.

5 And, finally, if I may draw your attention
6 to section 41 on page 18. I would like to read it sir.

7 "Since our appearance before the Commission
8 last May, one province -- Saskatchewan --
9 has adopted a universal compulsory medical
10 care plan. Within a year or two at the
11 most, the wisdom or error of that course
12 will be revealed. It will then be possible
13 to measure the quality of medical care,
14 the comparative cost and the public's
15 reaction to a compulsory plan operating
16 in a continent otherwise pursuing the
17 voluntary system. The Saskatchewan ex-
18 periment was a large and explosive one and
19 one whose results other governments, if
20 they are prudent, will await and assess
21 before embarking on a similar course.

22 If governments in the meantime will face
23 up to their first problem -- that of pro-
24 viding assistance for those unable to pay
25 even the most modest premium for their
26 medical care --- the problem insoluble by
27 private initiative will be removed."

28 Mr. Chairman, I and my associates will be
29 pleased to answer any questions which you may care to
30 direct to us. Thank you sir.

THE CHAIRMAN: Thank you Mr. Kilgour.
It is quite obvious that your submission here this morning
is within narrower limits than the previous one. You are



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facing up to this matter of providing coverage for everybody, regardless of age or pre-existing conditions.

Then on the top of page 5 one of the items to which you drew specific attention is where you say the problem divides itself into three main elements and the identification of the medically indigent group is the first. And then ten, you go on to say "Identification of the Medically Indigent Group".

You say: "The medically indigent may be defined as that group which, as long as no misfortune befalls it, is capable of providing for its own normal needs but which, in the event of accident or illness, requires outside financial help to meet the costs of treatment."

What about the unemployed person? The person who is employed and loses it, either for a short or a longer period? Do you exclude him from your definition of medically indigent?

MR. KILGOUR: Not necessarily Mr. Chairman, if I may say so. In fact, the scheme we envisage would be that of people who have available to them health, that all people would have available to them health insurance coverage, regardless of age or insurability, at a maximum premium in addition to all the coverage that is today available, so this would include coverage for a man who is unemployed for two months. He may merely continue to pay the premium of \$4.00, \$5.00, \$10.00 a month that he has to pay and the two months cost of carrying his medical insurance is a relatively minor factor in his total economic problem. If, on the other hand, someone by reason of unemployment is in fact in the low income group



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that we have suggested subsidy for, he would have already received a Government subsidy towards the cost of carrying health insurance.

THE CHAIRMAN: Now the reason I mentioned it is where you made interpolations: "in the event of accident or illness". Would you want us also to put in "or unemployed"?

MR. WATSON: If I might just make the point, what we are attempting to do there is to delineate the age of the group. That is, these people who are just at the age, and beyond the age they fall into a certain group. The unemployed sir are further back. They have, presumably, no income at all and therefore will be out of this group.

THE CHAIRMAN: Is there not a time when they are moving from one group to another?

MR. WATSON: Yes, indeed.

THE CHAIRMAN: This is the man I am concerned with. How would you see them being covered while they slide from relative capacity to pay to total incapacity to pay the premium?

MR. KILGOUR: This is really, sir, a generalization at the beginning, and the unemployed people are not necessarily indigent.

THE CHAIRMAN: Oh I accept that, yes.

MR. KILGOUR: So this is merely an attempt to say that there is a group that is close to the line.

THE CHAIRMAN: There is a sizeable group of retired judges that may not necessarily be indigent.



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4 Can we see that problem that I present of the man who is
5 unemployed for a year? He is certainly not going to
6 have any income from which to pay income tax, and there-
7 fore, he falls into the other group. These things are
8 not as cut and dried as that. Things happen; two or
9 three month period or a six week period or a six month
10 period, how are we going to take care of this fluid state,
11 in that sense?

12 MR. KILGOUR: Of course, our submission
13 suggests that this is the responsibility the individual
14 should look after. That is an individual situation, if
15 we make health insurance available.

16 THE CHAIRMAN: Supposing we start with
17 the precept that the individual cannot.

18 MR. KILGOUR: Mr. Chairman the unemployed
19 persons still have to arrange to buy groceries for their
20 families and where health insurance will be available at
21 a premium to all Canadians, it will be one of the more
22 modest elements in any family budget.

23 MR. BERRY: It seems to me that the
24 test which we propose here does work reasonably well. If
25 you would assume a man to make \$80. a week, if he is out
26 of employment for one, two or three weeks, he will remain
27 in the taxable group, and probably will pay income tax.
28 As his unemployment period lengthens, and his income goes
29 down, he would move out of one group into the other and
30 would become eligible for subsidy.

THE CHAIRMAN: That is the very man I
want to follow through that declining period of capacity
to pay. How are you going to take care of that person?



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MR. KILGOUR: The following year his premium will be paid, subsidized by Government. He would get one hundred per cent, under our proposal, of the premium for health insurance for himself and his family. It would not cut in in the first month but the following year, if he were unemployed, he would become eligible for a full subsidy of his health insurance premium.

THE CHAIRMAN: I can see where that can readily be, but he cannot wait for a year. He cannot space his illness to the time he becomes eligible.

MR. DREWRY: Would it not be fair to say that at the point he can meet the test that we now apply in many Provinces for the indigent person who is entitled to assistance, then at that point he begins to receive some form of subsidy?

THE CHAIRMAN: Something like that, I suppose, might necessarily have to be worked out. Now this individual has gone from the point where he was able to pay to the point where he was not able to pay the premium and then his circumstances improve. In the meantime, he may have had an illness which has affected his insurability. Would he then have to pay a higher premium or merely be reinstated to the category that he was in before, because your plan does pre-suppose a higher premium for certain conditions and age.

MR. DREWRY: But not more than the statutory maximum.

THE CHAIRMAN: That is true but more than the average healthy person would pay.

MR. WATSON: Mr. Chairman, we must assume



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that the policy is in force, has been applied for and is in force and a premium is being paid and this has been going on for some time. Then a man falls into a state of unemployment and his premium will be paid, up to a certain date, and then if he can prove that in the previous year his income was low, he would gain a subsidy and his policy would be continued. There would be no alteration in the policy by virtue of becoming unemployed, at that time. That would not affect his insurability.

Our submission is designed that at that point, when he falls into unemployment, if the test of the income tax in the previous year is such he would then qualify for subsidy at that point. I think it takes good care of the unemployed, although there is that, perhaps, hiatus of a few months, but it is based on the previous year's income.

THE CHAIRMAN: Now on the matter of change in the physical condition, this person who has got his coverage, and has received assistance for the period he was not able to pay the premium, then he becomes able to pay again. Is that a continuing situation or will any intervening deterioration in his condition mean that he is going to pay a higher premium?

MR. WATSON: We envisage, of course, under this plan that the premiums will continue, that the subsidy would likely continue. There would not be an interruption. If there was an interruption, then of course he might have to go into the maximum class, maximum premium. The subsidy would have to be such as

that the policy is in fact, has been applied for some
 is in force and a provision is made and this has been
 going on for some time. Then I am going to make a
 of management and his position will be paid, so to a
 certain date, and then if he can prove that in the
 years past his record was low, he would get a salary
 and his policy would be continued. There would be no
 alteration in the policy by virtue of his record.
 proved, at that time. That would not affect his
 insurability.

But when it is suggested that at that
 point, when he is in the hospital, at the point of
 the record card in the hospital, that he would
 then qualify for salary at that point. I think it is
 good care of the unemployed, although there is that
 perhaps, matter of a few months. But it is not on the
 previous record.

Now on the matter of
 change in the physical condition, that is a
 got his coverage, and has received assistance for the
 period he was not able to pay his premium, that he has
 comes able to pay again. Is that a continuing situation
 or will it automatically terminate on his condition
 when that he is going to get a higher premium?

MR. TAYLOR: We are not, of course,
 under on a plan that the premium will continue, and
 the policy will be likely continued. There would not
 be an interruption. If there was an interruption, then
 of course he might be able to go into the maximum class
 maximum premium. The policy would have to be such as



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to take care of him in that maximum premium class.

THE CHAIRMAN: Would you tell me why that should be?

MR. WATSON: I said might, of course.

THE CHAIRMAN: Why should it be? You would have exactly the same condition as when he got his coverage when he was able to pay, when he was well and he takes care of his coverage. His policy carries on automatically. It would not envisage a change in premium merely from the fact that something happened to him while he was covered. Why should the fact that he became unable to pay put him in a position where he is going to have to pay a higher premium?

MR. KILGOUR: That would only happen in the event there had been some serious deterioration in his health, in the meantime. It is unfortunately true that companies, or service plan companies cannot look behind, completely, all the individual circumstances that apply and there are many people who would choose to buy health insurance one month before they were told they had to have an operation. This is a highly substandard risk and one cannot necessarily say with one man who was out for three months, because he was unemployed. Nine out of ten of them would be permitted to enter plans again without any change. This is true of most group plans.

There could be circumstances where that man's unemployment, if it were accompanied by a period of some serious deterioration in health, he would have difficulty in paying standard rates, but here we



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4 have made available a policy at a maximum rate so that
5 under no circumstances can he, under our proposal, be
6 denied coverage at a reasonable premium rate, and this
7 is a considerable forward step, we believe.

8 THE CHAIRMAN: You can appreciate
9 the reason I bring this forward in this way is that others
10 who say that a state operated plan, which covers every-
11 body, is not subject to this kind of change in an in-
12 dividual condition.

13 MR. KILGOUR: That is true, and if that
14 were the only point, I think one would admit its merit.
15 There are many other difficulties in these schemes.

16 THE CHAIRMAN: I think that is the key
17 to the difference between the two philosophies, where
18 you get this complete coverage without regard to con-
19 dition or ability to pay, or anything else.

20 MR. KILGOUR: You have to pay your
21 premium. In Saskatchewan they have to pay a premium.
22 There are very serious penalties if you do not pay a
23 premium to the government.

24 MR. WATSON: In a way that could be
25 thought of as a supplement to unemployment insurance;
26 a benefit for this type of insurer, upon becoming un-
27 employed and being sick. This is an unemployment in-
28 surance benefit to the sick unemployed. It could be
29 introduced, if that was thought to be necessary. There
30 is, I believe, in the present statute benefits to the
sick unemployed.

MR. DREWRY: That was the point I was
trying to make when I said you reach a point where



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4 applying the normal test one would be entitled to this
5 assistance and then as Mr. Watson says, the assistance
6 could pick up the premium at that point.

7 THE CHAIRMAN: Somewhere in your sub-
8 mission here this morning you refer to what might still
9 be in the experimental stage in British Columbia. Are
10 you in a position to tell us what that proposition is?
11 I understand it is a form of partnership between the
12 carriers and the medical profession.

13 MR. KILGOUR: Mr. Chairman, I think I
14 can speak to that. It is not final, but we have had
15 conversations to the point that the service plan, and
16 the insurers believe and we believe we are substantially
17 on the road to putting in just such a plan as we have
18 proposed, namely, that everyone in that Province would
19 be able to buy from any agency doing business in the
20 Province inclusive coverage at a maximum stipulated premium
21 rate and, in effect, we are making headway in that Pro-
22 vince. In putting into effect the Association plan,
23 it would require Provincial Legislation which we have not
24 yet approached the Government for, but we have had most
25 encouraging conversations in one Province. We believe
26 we can put this plan into effect. We believe we have
27 it substantially ready to go. It is not going yet.

28 THE CHAIRMAN: Is it the expectation
29 that it might be able to be in operation within, say,
30 a certain period of time? A year, or something like
that?

MR. KILGOUR: Some of us hope it might
be going by the first of next year.



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MR. DREWRY: That is what we are working towards.

THE CHAIRMAN: I was wondering if we would have it in operation in Canada, the two aspects of it in Saskatchewan, the Government plan and in another Province, the other experiment, running side by side?

MR. WATSON: That is exactly our hope Mr. Chairman.

MR. KILGOUR: We are working to that end.

MR. REID: It takes at least a year to test the other system.

THE CHAIRMAN: It takes some time. There is no doubt about that.

MR. DREWRY: I think perhaps British Columbia is not the only Province that we are thinking of. It so happens that we are perhaps farther along the road in our discussions there, but I think I am right in saying Mr. Kilgour that the Association is pressing forward with this plan that we put before you, to endeavour to get it implemented in other places.

THE CHAIRMAN: You may remember when we were discussing the coverage in May, I brought up this matter of the limitation of payment for psychiatric care where your proposition was that, basically, you would pay eighty per cent, or your plan would pay eighty per cent of the cost, general cost of medical care, and so forth.

MR. WATSON: Out of hospital?

THE CHAIRMAN: Out of hospital. When



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4 you dealt with psychiatric care, you said you would only
5 recommend the payment of fifty per cent. I had in mind
6 that I had asked somebody to recompute, if possible, what
7 the difference would be in the premium if, instead of
8 treating psychiatric care separately down to fifty per
9 cent, what it might be if the plan called for paying
10 eighty per cent of psychiatric care as with all other
11 illnesses. Were you able to do that? Did you give
any consideration to it?

1B 12 MR. DREWRY: I am sorry, sir, if that
13 was your intention ---

14 THE CHAIRMAN: I did not spell it out
15 very clearly.

16 MR. DREWRY: We did not understand it.

17 THE CHAIRMAN: When I re-read the record,
18 I don't blame you for not picking it up.

19 MR. KILGOUR: As a plan, as a proposal
20 obviously, because coverage would be amended or re-thought
21 out from time to time. This particular type of coverage
22 is not in any province as yet; each one will have to be
23 put in a specific, concrete way for each province, and
premium rates and benefits fixed at that time.

24 MR. WATSON: Perhaps, Mr. Chairman, we
25 should re-state what I stated at that time, that this
26 particular element in psychiatric care was put in there
27 as a deterrent against abuse of the plan. It was not
so much as to cost, it was to stop abuse.

28 THE CHAIRMAN: The psychiatrist who
29 gave you that advice I think should consult one.

30 MR. REID: I think we pointed out that



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you begin with psychiatric care, you said you would only
recommend the payment of fifty per cent. I had in mind
that I had asked somebody to estimate, if possible, what
the difference would be in the payment of treatment of
treating psychiatric care say twenty down to fifty per
cent, what it might be if the plan called for paying
eighty per cent of psychiatric care as well as other
illnesses. Were you able to do that? And you give
any consideration to it?

MR. DUBOIS: I am sorry, I am not sure, but I think
was your intention was.
THE CHAIRMAN: I did not speak of it
very clearly.
MR. DUBOIS: We did not understand it.
THE CHAIRMAN: When I heard the report,

I don't blame you for not picking it up.
MR. DUBOIS: As a plan, as a proposal
in general, because coverage would be extended to the thought
out some time to time. This part could come off coverage
is not in any province as yet, each one will have to be
put in a specific, concrete way for each province, and
premium rates and benefits fixed in that way.

MR. WALTON: I thought, Mr. Chairman, we
should recall that I asked at that time how this
practical element in psychiatric care was put in there
as a deterrent against abuse of the plan. It was not
so much as to cost, it was to stop abuse.
THE CHAIRMAN: The psychiatrist who
gave you that answer I think should consult one
the REID: I think we pointed out that



Reid 12645

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4 it was on the advice of the medical profession.

5 THE CHAIRMAN: Yes, and that was advice
6 that I just could not accept.

7 MR. REID: I think we are flexible.
8 We are following the advice of doctors - something that
9 would be subject to very substantial abuse.

10 THE CHAIRMAN: Supposing you forgot about
11 this advice, poor or good as it may be, you calculated a
12 premium roughly, I was wondering if that maximum premium
13 you spoke of might be increased if you dropped that
14 limitation you mentioned there.

15 MR. KILGOUR: That could be further
16 explored, sir.

17 THE CHAIRMAN: I wonder if you could.
18 I am asking you specifically now. I should have done
19 it more specifically before.

20 COMMISSIONER FIRESTONE: Mr. Kilgour and
21 gentlemen, we are very much indebted to you for spelling
22 out your proposal and giving us examples of how your pro-
23 posed plan could work. I think the illustrative in-
24 formation contained in this supplement is very useful to
25 us.

26 May I refer you to paragraph 12, sub-
27 paragraph 2, on page 7 in which you say that the cost of
28 this subsidy contributing to the premium payments of the
29 medically indigent "would be paid in some way by the
30 various levels of government." Do I understand from
this sentence that you had in mind that the cost of this
subsidy would be borne by the federal, provincial and
municipal governments?



Kilgour

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MR. KILGOUR: Perhaps just two, in our thinking perhaps two levels of government, perhaps both federal and provincial might participate.

COMMISSIONER FIRESTONE: Who would administer the plan, the subsidy plan?

MR. KILGOUR: The federal government, by our thinking, would be the one that would provide the mechanics of administration of sending out the vouchers. I think each plan would have to be determined provincially, so that the provincial governments would be involved in setting it up, the federal government would be involved in the machinery, for distributing the subsidy.

COMMISSIONER FIRESTONE: You say on page 15 that the Federal Income Tax Department would be concerned with sending out the income tax forms and the vouchers, and presumably the vouchers mean money and presumably the federal government would be reimbursed by the provincial government.

MR. KILGOUR: That is right, sir.

COMMISSIONER FIRESTONE: Do you know of any system whereby the provincial government makes payments to the federal government?

MR. WATSON: I know of the reverse, sir.

THE CHAIRMAN: Dr. Van Wart made the suggestion that it could only come from New Brunswick where the river runs uphill.

MR. BERRY: What could be done, Mr. Chairman, is by the grants from the government, and then it would not be necessary for the government to pay the grants in Ontario and ask Ontario for it back. They take



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TORONTO, ONTARIO

Berry

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it into account in their total dealings with the province.

COMMISSIONER FIRESTONE: What you had in mind, Mr. Berry, was that the federal government is obligated to pay the Ontario government X dollars for, say, hospital insurance, and then the Ontario government is responsible to pay the federal government in this proposal Y dollars and the federal government deduct Y from X. Is that what you are visualizing?

MR. BERRY: It seems to me that this is sort of making it much more definite than we intended to imply. Maybe the wording is not what it should be. It did not seem to us it was our business to say where the final cost should rest; we merely indicated that it could turn out that way if the governments wanted to do it. It is not up to us to tell them how to do it.

COMMISSIONER FIRESTONE: We come to you for advice, and the plan on the surface seems to make sense. You say if the medically indigent cannot pay all the premiums they should be subsidized at certain rates at certain times. That seems to make sense. We wanted to know how that would work in practice, and I am wondering if it could really work with the federal government administering a plan in which the provincial governments would have to contribute financially. Traditionally it has been the other way around. This question relates to the practicality of this plan, because the question is: Are we going to have one plan or have ten plans? But if I understand you correctly, you would have one plan, but how would that plan work?



Kilgour

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MR. KILGOUR: Mr. Chairman, I believe we would have to end up with a variety of plans in each province, in different provinces, because there are different costs incident to medical care in different provinces in Canada. There are some provinces which have very effective schemes at work to provide medical care to large groups of people who may want to continue and be exempt from plans such as this. So as I see it, the federal government would want to administer the plan in relation to each province, and in effect they are doing it as an agent for each province in the distribution of these vouchers, as we have suggested, and the final element of cost would have to be determined between each province, and we do not want to say what it should be in each area.

MR. WATSON: You have the position where the contribution by the federal government was made available only if the provincial governments did certain things, and therefore this, I think, would work the same way, that the subsidy would be made available in a particular province under certain conditions and providing the province was willing to make a contribution. It is true that the river runs uphill, but it also has to run downhill. If the provincial government did not want to make this contribution, then there would be no subsidy in that plan.

THE CHAIRMAN: You do see that the same person might pay a different premium in 1963 in Alberta than he might pay in 1964 in Nova Scotia, the same person and the same quality of health, and so forth.



Watson 12649

So this does not bring us to any balanced sort of equalized opportunities throughout Canada.

COMMISSIONER VAN WART: We have that to-day, have we not, in, say, the railway insurance scheme, varying in different provinces?

MR. WATSON: We are bound to have that situation as long as the constitutional powers of the province are as they are. I do not think that can be changed unless the constitution is changed.

MR. BERRY: The premium would vary only between provinces if the benefits vary.

COMMISSIONER FIRESTONE: Are you talking about difference in the premiums or difference in benefits as to what benefits should be provided and what premiums should be paid?

MR. WATSON: We haven't been talking of different levels of premiums in different provinces. We haven't suggested there would be different levels of premiums.

THE CHAIRMAN: I am afraid Mr. Kilgour said so.

MR. KILGOUR: And I think I would support that by suggesting that today there are different levels of medical costs in different provinces, and for the same benefit one could charge a lower premium in certain parts of Canada than in other parts. This again is beyond our province to be final, because each province and the medical profession in those provinces in the service plans would have to co-operate in the establishment of this plan. So it is not possible for us to say that there



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will or will not be different levels of premiums in different provinces in Canada.

COMMISSIONER BALTZAN: What do you mean by "medical cost"? What is included in a medical cost? It is rather a broad term. We have the physician's charge, the nurse's charge, the hospital cost. What do you mean by "medical cost"?

MR. KILGOUR: I was thinking in terms of total cost.

THE CHAIRMAN: Just call it costs.

MR. KILGOUR: We know that in various provinces the fee level is higher, therefore you end up with a higher cost per capita than other areas where the fee is less.

COMMISSIONER BALTZAN: So you confine it to the physician's cost?

MR. DREWRY: Surgical and medical.

COMMISSIONER BALTZAN: But to the physician, not things like physiotherapy and the like.

MR. DREWRY: Yes.

MR. WATSON: The various services which are set forth in our illustrative plan, you will recall the medical and surgical procedures did not include drugs and medicines, so we did have a separate premium for drugs.

MR. DREWRY: In Appendix II of our main submission, starting in paragraph 3, the benefits, they are spelled out there quite clearly. I could read them if you wish.

THE CHAIRMAN: No, we did not think it



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was necessary in this context this morning; we are going forward from your main submission.

COMMISSIONER FIRESTONE: Mr. Kilgour, did I understand that the standard of services would be uniform across the country under this plan, the services that would be covered?

MR. KILGOUR: Yes.

COMMISSIONER FIRESTONE: And that the premium which would have to be paid across the country might vary, depending on the circumstances; is that correct?

MR. KILGOUR: Quite true, sir.

COMMISSIONER FIRESTONE: Who would tell the federal government, assuming they administered the plan, what it should be in each province?

MR. KILGOUR: This would have to be worked out in each province with the provincial authority, I believe.

MR. WATSON: We did have an idea there that the voucher that would be issued would be in general terms; that is, a certain proportion of a premium would have to be applied for, it can only be used for a specific purpose, it would be valuable up to a certain point which would be identified by the policy, but not more than a specific sum which would be the maximum statutory figure in that province. I think it could be worked out on that basis.

COMMISSIONER FIRESTONE: You appreciate if the federal government is to send out vouchers it would in effect be a subsidy, that subsidy is a proportion of



Kilgour

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4 the premium, and therefore the administering agency does
5 not only want to look at the premium which is higher
6 than the maximum statutory one but whether it is reasonable
7 in the light of the coverage. Do you visualize the
8 federal government going into the question of examining
9 all the premium arrangements in all the provinces?

10 MR. KILGOUR: This would be a provincial
11 affair, I think, sir.

12 COMMISSIONER FIRESTONE: All right; would
13 you explain to me how it would work?

14 MR. WATSON: This is going into un-
15 chartered seas, so this is only the conclusion of our
16 Committee as we considered this matter.

17 We thought that it would be operated
18 on a similar basis to what is called Connecticut 65 or
19 Massachusetts 65 or New York 65, details of which are
20 available. Those plans are operated as master group
21 contracts, and the persons applying for them are issued
22 certificates, so that the accounting in each one of those
23 contracts is identified and is available; and it might
24 be possible, assuming that our membership was in agreement,
25 we thought it might be possible to have a similar kind of
26 thing and have a master contract in a particular province
27 which would be subject to auditing, and so on, just as
28 any other contract is audited as to what claims and
29 premiums are paid, and so on.

30 Of course, the individual employer has
the right to terminate the contract if he is not satisfied,
and the federal government would have the right to terminate
it.



Kilgour

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COMMISSIONER FIRESTONE: So you visualize each provincial government working with each plan in the province and forwarded to the federal government and the subsidy would be passed as determined in the master contract?

MR. KILGOUR: Yes. I think that one could say that each provincial government is going to have to set up its own conditions and ground rules under which the federal government would issue subsidies to the people in that province.

COMMISSIONER FIRESTONE: In other words, you are visualizing a plan whereby the federal government would administer ten different provincial plans.

MR. KILGOUR: There might be only two across Canada. There would be, I believe, sir, important variations in certain provinces, because these subsidies would by no means go to one hundred per cent of the people who are not paying income tax; there would be a large number of people who would not require their subsidy for other reasons. So there is going to be a rather complex but straightforward set of ground rules. They would have to be provincial ground rules.

COMMISSIONER FIRESTONE: The federal government would distribute these vouchers according to the provincial ground rules.

MR. KILGOUR: Yes.

MR. WATSON: And they would have to be set forth in a master contract, as we see it.

MR. DREWRY: The federal government is also providing the mechanism for eligibility for the subsidy.



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COMMISSIONER FIRESTONE: What do you call it when a federal government provides the mechanism for eligibility, issues cheques. Is that not administering?

MR. WATSON: The federal government could issue the vouchers and the vouchers could become a direct charge against the province by arrangement. All we are doing is providing the administrative machinery, and the administration of the plan is a provincial one.

COMMISSIONER FIRESTONE: Now, if the vouchers are then to be honoured by the provinces, they would do that and the federal government would make a contribution. Earlier you suggested that the federal government would provide these vouchers and would be reimbursed by the provinces. Now the federal government would reimburse the provinces.

MR. WATSON: We have tried to avoid taking the presumption of saying who is going to pay how much of what as between the different levels of government. The federal government already has the income tax machinery, and it would be our thought that they would only use that machinery in order to make subsidies available in accordance with the plans which would be supervised and set up provincially. How much is paid by the province or by the federal government we thought was beyond our province to suggest.

COMMISSIONER FIRESTONE: I take it, if I understand you correctly, that the federal government would issue these vouchers, and the vouchers have to be honoured and the money has to be sent to the insurance companies or other carriers, and the federal government



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would be the people who issued vouchers and the insurance carriers would present them to the federal government. Is this the way you visualize it?

MR. KILGOUR: Yes.

COMMISSIONER FIRESTONE: And the federal government would then be reimbursed by the province: we have paid fifty per cent; please reimburse us.

MR. KILGOUR: Yes.

COMMISSIONER FIRESTONE: You said that if commercial carriers, and so on, would administer such a program there would be an audit of their operations.

MR. WATSON: It seems whenever public funds are paid to someone the government would always expect that they should be able to audit, and if a group master contract were to be used along the lines I have indicated, that auditing procedure, which is going on now, of course, you understand - I just wanted to make the point that if there were ten master contracts, this is not a complicated thing because this auditing is going on now with respect to the civil service employees; I believe a premium of twenty-five million dollars is paid out each year, and they have to satisfy themselves as to the disposition of that money, although it is largely employee money. But I always envisage the same mechanism. It is a very small piece of work, because it would only be done on the basis of an annual report.

COMMISSIONER FIRESTONE: And you feel the provincial government would have no objection to a federal government audit of their operations?

MR. KILGOUR: We feel that there should



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be adequate supervision to see that these plans are operated in the highest standards possible.

COMMISSIONER FIRESTONE: Do you mean standard of insurance or standard of medical care provided?

MR. KILGOUR: We cannot insure the standard of medical care.

COMMISSIONER FIRESTONE: It is not what the insured gets for his money?

MR. WATSON: It is a financial audit.

THE CHAIRMAN: Just before we leave that, we have a great movement of population from one province to another. How would that be affected, what about that mobile population that we have? How would the scheme work in a mobile population?

MR. KILGOUR: Virtually no problem. A great many of the people are insured under commercial plans, group plans. This is not important. It works very smoothly now. If a provincial plan were available, I do not think it would be an important matter; it would be one of the minor elements, moving from one province to another.

COMMISSIONER FIRESTONE: In paragraph 20 of page 9 you say: "...it should be noted that the Association's proposals contemplate no legislative or other compulsion or restriction on any Canadian. The only compulsion envisaged is that to be applied on the insurance carrier."

Now, it has been suggested by some that there is an inconsistency in this proposal, that you say there should be no compulsion as far as the insured is con-



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cerned but there should be compulsion as far as the insurance carrier is concerned. Have you any comments?

MR. KILGOUR: Well, we certainly don't resist this suggestion; in fact, we recommend this legislation which would require all insurers to participate is desirable to bring this petition about. Many of us operate under provincial and state law of forty or fifty states.

MR. WATSON: Well, perhaps the word "compulsion" is not the best one. What we had in mind was our licensing requirements. We are already restricted in what we can and cannot do.

MR. KILGOUR: It is not really compulsion; if somebody does not want to conform, they do not need to do business in that area, but it means all companies doing business in that area would have to conform to this plan.

COMMISSIONER FIRESTONE: You feel legislation would be required to bring about this compulsion? You could not develop a plan on a compulsory basis?

MR. KILGOUR: We think it would be extremely dangerous if it were not made to apply to all characters. In order to be permanently successful we think that all insurers should become a member of this, or participants in the pool.

COMMISSIONER FIRESTONE: If some companies do not want to comply, you would suggest they go out of business?

MR. KILGOUR: Only that area of the business. Only the health insurance field. Only the personal medical care field.



...the fact that the ...

...any comments?

MR. KIDDER: Well, we certainly don't

...this suggestion; in fact, we recommend this leg-
islation which would require all industries to participate
in desirable to bring this legislation about. Many of us
operate under provincial and some law of force or they

MR. KIDDER: For instance the word

"compulsion" is not the best one. What we had in mind

was our licensing requirements. We are already restricted

in what we can and cannot do

MR. KIDDER: It is not really compulsion

of something that not want to control; they do not need to

do business in that area, but it means all companies doing

business in that area would have to conform to this law.

Compulsion is a strong word. You feel leg-

islation would be required to bring about this compulsion?

You could not develop a plan on a compulsory basis?

MR. KIDDER: We think it would be

extremely dangerous if it were not made to apply to all

characteristics. In order to be permanently successful we

think that all industries should become a member of this

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...the fact that the ...

MR. KIDDER: In the area of the

business. Only the health insurance field. Only the

personal medical care field.



Kilgour

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COMMISSIONER FIRESTONE: Thank you very much. On page 13, in paragraph 28 you include the sentence: "The guarantee of medical care involves control of the profession." I wondered whether you could elaborate on that sentence? What had you in mind?

MR. KILGOUR: Well the fact that our contracts undertake to reimburse patients for medical care expense is a financial arrangement. We have no means of saying how many doctors per thousand of the population there are going to be.

In effect, that is an axiom that an insurer's only arrangement is with the mechanism of the payment for care. We cannot guarantee that the services will be available.

THE CHAIRMAN: That is what you are talking about; a guarantee of the services, not quality in this sentence?

MR. KILGOUR: Quite.

THE CHAIRMAN: You are not speaking of quality?

MR. KILGOUR: Right. We point out our inability to direct or control the provision of care, and we go further and say that we do not think it is a province in which we should have either control or responsibility.

THE CHAIRMAN: You go further and say nor should the government?

MR. KILGOUR: I believe that very strongly sir.

COMMISSIONER FIRESTONE: Would you just elaborate why? We know that you believe in this. Would



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you just explain why?

MR. KILGOUR: Why Government should not have control?

COMMISSIONER FIRESTONE: Yes.

MR. KILGOUR: This would take me about thirty seconds. I think a good example perhaps is going on right today in Saskatchewan. There we have a Government that has launched or tried to launch a state scheme and we have already seen the dramatic reduction in the medical care available to the people of Saskatchewan.

Many, many doctors have left. The rest are apparently distinctly unhappy about the approaching problems which have not yet been resolved. Their troubles there have merely started.

The question of Government conscripting any profession is one on which I believe the people of this Continent are not ready for, and not willing to submit to.

COMMISSIONER FIRESTONE: Is Government conscripting a profession if it allows the profession to work outside the plan?

MR. KILGOUR: In a sense the working outside the plan is almost theoretical. The profession in the Saskatchewan scheme, since you have arranged taxes to pay, on the sales tax to pay for the plan, you have to pay a premium whether you are going to use the services of the doctor, but essentially people outside the plan would have to have patients who were prepared to pay double for all their medical care. That is essentially the way it works in Britain. People will pay over again



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You must explain why

Mr. KENNEDY: The Government should not

Mr. KENNEDY: I am going to ask you about

thirty seconds. I think a good example perhaps is going

on right today in Saskatchewan. There we have a (name)

man that has remained or tried to remain a state doctor

and we have already seen the results of that in the

medical care available to the people of Saskatchewan.

Now, my doctor has left. The rest

are apparently clinically unhappy about the situation

problems which have not yet been resolved. What troubles

there have merely started.

The question of government contracting

any profession is one on which I believe the people of

this continent are not ready for, and not willing to sub

mit to.

Mr. KENNEDY: I am going to ask you

contracting a profession if it means the profession

to work outside the plan.

Mr. KENNEDY: In a sense the working

outside the plan is almost theoretical. The profession

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to pay, on the other hand to pay for the plan, you have to

pay a premium whether you are going to use the services

of the doctor, but essentially people outside the plan

would have to have patients who were prepared to pay

double for all their medical care. That is essentially

the way it works in Britain. People will pay over again



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for medical care from private practitioners," but it is not by any means the scheme that is available to," or the arrangements available to all doctors in the Province. the Department. COMMISSIONER FIRESTONE: No. Presumably some doctors choose to work under the plan and some doctors choose to work outside the plan so where do you see the conscription to which you referred earlier?

MR. KILGOUR: This is the Saskatchewan plan?

COMMISSIONER FIRESTONE: You spoke in general terms. You used the Saskatchewan plan to illustrate the point. I am just trying to understand whether it is Saskatchewan or another province. You may have seen some announcement recently that certain groups in another province have been speaking of a somewhat similar plan allowing physicians, perhaps, to work outside the plan or inside the plan.

This general principle is one that could apply in any Province, not just Saskatchewan. How do you feel about the general principles?

MR. KILGOUR: In the final analysis if a Government guarantees a service, they have to become the absolute dictator as to how those services are available; how they are to be performed. There are not enough medical men in any community to give medical services of an unlimited degree.

To do the checks and balances of how often someone can call a patient, or what may be done, are, in a sense, regulated by the doctor and the patient together. There is an element of self-discipline.

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Once a blank cheque is drawn, and everyone in the public is able to obtain whatever they want from the Profession from this guarantee by Government, the Government in the last analysis has to become the absolute boss and say it shall be done this way this time, and shall be done that way another time and regulate both the character and the manner in which the profession is practised and the compensation that will be paid to each person within the Province.

I do not believe there is any way of running a medical care plan on a compulsory basis without someone becoming the complete boss. That has to be Government and, in the final analysis, I am one of those who feel very strongly that this breaks down; that he cannot give as valuable a service as medical care under a dictatorship, is the word. It has to be run by someone. I do not think anyone in private business or Government has the capacity to discipline and regulate and run everyone in the medical profession.

COMMISSIONER FIRESTONE: Do you feel that the Government has to tell a doctor how to practice? Would the Government just not make arrangements for the final reimbursement, leaving the practice of the profession to the medical practitioner and his professional society?

Could there not be this division of responsibility in operation?

MR. KILGOUR: In theory it is plausible. In fact, in my judgment, it cannot work that way because if you are set up as Saskatchewan - and again I use Saskatchewan as one I am familiar with, if a plan



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4 is inaugurated where somebody is merely paid on a fee
5 schedule at the end of the year," when some doctor who
6 has worked eighteen hours a day and is trying to serve
7 7,000 people has earned an income of by ordinary standards
8 is rather astronomical," somebody says this is too much
9 money. We have got to change it.

10 COMMISSIONER BALTZAN: Would you gentlemen
11 just allow me to interrupt? You are using the word plan,
12 and I question it. I want somebody to look up the Act.
13 Does it use the word "plan"? They can work inside and
14 outside the plan? Both of you are talking about the plan.
15 If I remember correctly, that word is not used there. I
16 stand to be correct. I would like to have it corrected.
17 Is the Act available? Does it say you can work inside
18 the Act or outside the Act? It does not use the word
19 "plan"? That is an inconsistency there, if it says
20 you can work inside the Act or outside the Act.

21 MR. KILGOUR: You are correct sir.
22 It refers to inside and outside the Act.

23 COMMISSIONER BALTZAN: You are talking
24 about plan. Some of the things you say, if the word
25 "plan" were used, would apply to your argument. If the
26 word "Act" were used, your argument is not entirely
27 applicable.

28 MR. KILGOUR: I should have used Act
29 in relation to Saskatchewan.

30 COMMISSIONER FIRESTONE: I am partly
responsible for this because I suggested to Mr. Kilgour
to generalize what is unrelated to Saskatchewan. We are



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4 is inaugurated where something is being done on a
5 scheduled at the end of the year, and some of the
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dealing with the principles. I think you have explained your point of view with vigour and conviction and in a very helpful manner. Thank you very much Mr. Kilgour.

One last question. This being a rebuttal hearing, we have received rebuttals from various groups dealing with various matters. I would like to quote to you one sentence in the supplementary submission of the Canadian Labour Congress, from whom we will be hearing later today. It refers to your own submission that you made to us earlier this year and I quote from pages 8 and 9 of their supplementary submission dated September 24: "Thus, for example, it states..." (referring to your Association) "with reference to a public plan that 'The possibility of qualitative and quantitative deterioration of health care services should not be overlooked' (page 10, paragraph 3, sub-paragraph 7)". Then the brief continues: "So strongly suggestive a statement should be backed up by supporting evidence." In view of the considerable number of public plans that exist in other parts of the world, any evidence in support of such a statement should surely have come to the attention of the Association."

I wondered Mr. Kilgour whether you have any comments on this observation?

MR. KILGOUR: Yes Mr. Firestone, I think such a view can be well supported on several scores. The facts that we are accused of having made submissions that the possibility of qualitative and quantitative deterioration of health care services should not be overlooked, it was only in recent months



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we have seen exactly what has happened in Saskatchewan.

I am reliably informed that there is not a neurologist left in that Province. That may not matter much unless you have cracked your skull against the windshield.

I was only last week in a community where there is literally only the one doctor serving 7,000 people. Now this is quite impossible. The physical capacity of one man is not capable of this, and this has been done by creating conditions under which people do not want to work so that there, I think, are two illustrations where both qualitatively and quantitatively the introduction of a compulsory plan has deteriorated the very thing it was designed to improve. Then, certainly, the fact we heard recently, and it has been quoted frequently the remark by Lord Taylor, who was out in Saskatchewan as the mediator. He has himself made some very positive statements about the deterioration of medical care in Britain.

We did file, I believe, with the Commission previously his statement from the British Medical Journal of December 9th, 1961, when he refers to British medicine as a pretty ghastly, awful picture, facing a new and desperate situation. This is the same Lord Taylor, I believe, who came out to help put the plan into effect.

There is one man who is closer to the British situation than I am who holds that view and again we would be glad to file a copy of this statement Lord Taylor made in the British Medical Journal.

COMMISSIONER FIRESTONE: On the comment



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4 you have made about the Saskatchewan situation, the
5 suggestion might be made that these are temporary dis-
6 locations that any new plan faces when it tries to produce
7 different methods of payment and different methods of
8 providing services. Would you feel that this deterioration
9 is of a more permanent character, not just interim pro-
10 blems with which any new program is faced? You may face
11 it with your suggested plan. Any new plan will have bugs
12 in it. I do not know of any plan, Government or private,
13 that would be perfect from the day you start it. Would
14 you feel that there is more to it? This is not just a
15 temporary situation but there is something basic in this
16 compulsory plan that cannot make it as efficient and as
high standard an operation as many Canadians want it to be?

17 MR. KILGOUR: I feel that is a basic
18 and fundamental thing, that if you, say, circumscribe a
19 profession with as dedicated people as the medical pro-
20 fession have, that it becomes unattractive in terms of
21 conditions under which one is going to work, and in terms
22 of the dignity and pride which makes one feel he is an
23 independent, self-respecting citizen not having to conform
24 to every rule and regulation. To me, it is fundamental.
25 Anything which purports to demean the stature of anybody
26 by telling him you have got to do this thing, that makes
27 the profession less attractive to the kind of man one
28 would want to have going into that profession, while the
29 loss of many men who leave in rage or in pique, or dis-
30 gust, one may recapture in time but there is probably
a permanent loss in terms of character of people that
choose to go into that activity in which they are going



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to be, as far as I know, permanently circumscribed and told how they will perform.

COMMISSIONER FIRESTONE: Thank you Mr. Kilgour. You and your associates have been most helpful.

MR. REID: I think it is worth referring to the fact that Dr. Casey Rutley, who is, to my knowledge about as well informed as anybody in the world on medical care plans all over the world - he travelled something like 200,000 miles, most of it to study medical care plans in other centres. I believe he is really well informed and is in contact with a lot of the top people in the United Kingdom. He is the only, I think, non-resident who has ever been President of the British Medical Association. I think he is the authority for the statement that the doctors in the United Kingdom average eight minutes per interview with their patients because they are so swamped. The situation would be even worse if it were not for the fact there are a great many foreign medical students in Great Britain; many of them perhaps only there temporarily.

MR. BERRY: Mr. Kilgour's comment when he spoke about whether this is a normal situation, Lord Taylor's speech in the House of Lords was made thirteen years after the British plan was put into effect.

COMMISSIONER STRACHAN: Mr. Chairman there is reference made at the bottom of page 9 where the individual Canadian will continue to be free to buy or not to buy as little or as much health insurance as he pleases. How much of that little or much health insurance is a subsidized group, and in the group which is able to



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buy as little or as much insurance as he pleases, is that individual going to be confused by the so-called small print?

MR. KILGOUR: Buy as little or as much, if I can speak to that point, our plan envisages that no one is required to buy health insurance. There are very many young people, for example, that just start working at their first job. They conclude they will not buy health insurance for five years, until they acquire some possessions, and so on. And they get away with it. Some of them get away with it. They are not required to do it.

There are many other people in moderate circumstances, or reasonably well to do - one of our great problems has been covering the farm population where the farmers are accustomed to pretty substantial swings in the income and will not voluntarily buy a policy that is going to cost him \$50. or \$100. a year. Many of them will simply not buy it unless they are required by law to buy it. This pertains to those accustomed to swings that frequently run at more than \$100. or \$200. every year, and, therefore, we feel that people should be able to buy none, or the degree of coverage that they choose.

When you speak of fine print, I do not think that is something that is an important factor in the health field today but I would invite any of my confreres who want to speak to that.

THE CHAIRMAN: Contracts are statutory.

MR. KILGOUR: Most of them.

MR. REID: I think the point Dr.



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3c) Strachan has in mind is the ability to terminate a policy at age 60, or something like that. Under what we are proposing anybody can get it at the maximum premium and the policy, that goes on indefinitely, regardless of age. You can still be paying for that premium at 80 the way our plan works, so there is no termination clause in it on an individual policy.

MR. WATSON: Perhaps Mr. Chairman I will just add one more point. The subsidy in this submission is directed to the subsidy of the medically indigent. We had in mind that the subsidy might very well be limited to policies, to the illustrative type that we have been suggesting which have no small print. Of course, none of our policies have any small print. The illustrative plan is a comprehensive plan and we had thought that when we come to the subsidy that that subsidy might be limited only to the comprehensive plan which we have been discussing at this hearing.

It might well be a condition that the subsidy would not be given for any less comprehensive plan. If the individual elected to buy that, that could be a condition that could be introduced.

COMMISSIONER STRACHAN: Rather than call it small print, I am referring to it as the difficulty of the average policyholder to interpret the legal terminology of a policy and know exactly what he is getting and what he can expect in the event of certain conditions arising.

MR. WATSON: I understand. It is just an expression. You just wanted to clarify that point.



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THE CHAIRMAN: Dr. Baltzan have you any questions?

COMMISSIONER BALTZAN: No questions, except I want to catch up with the latest information. What happened to the two programs or plans two of your companies offered?

THE CHAIRMAN: I think the reference is in paragraph 26, on page 11.

COMMISSIONER BALTZAN: "Last June... one of our member companies introduced a medical-surgical insurance plan which it offered to all residents of Ontario without regard to their age, sex, occupation or condition of health." And then at the bottom of the page "Another company has recently introduced a new health insurance plan designed to meet the needs of individuals and husbands and wives over 65 years of age." I am referring to these two plans.

MR. KILGOUR: Sir, we had not felt that they were basic to our submission, other than to report the companies are moving into this field we think very soundly and most encouragingly, but we would not want to have this detract from our basic proposal which is that together we try to work out this plan to make coverage universally available to all Canadians with a maximum premium.

COMMISSIONER BALTZAN: I just wanted to know something about them.

MR. KILGOUR: They have, I think, been highly successful.

COMMISSIONER BALTZAN: They have been



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implemented? It is in process now?

MR. KILGOUR: Yes.

THE CHAIRMAN: The use of the mass enrolment technique is that necessarily essential to this kind of a program on a voluntary basis?

MR. KILGOUR: Are you referring to the same points sir?

THE CHAIRMAN: Yes.

MR. KILGOUR: Is the mass enrolment technique --

THE CHAIRMAN: Essential to this plan that first went in in Ontario. It was based on mass enrolment within a set period. We would only accept applications at certain times of the year.

MR. DREWRY: So does our plan, we suggest.

THE CHAIRMAN: I know that. What I am asking you now is, is that essential?

DR. EMMETT: You cannot, I assure you, insure the house after the fire starts.

MR. KILGOUR: It is certainly essential if one company is trying ---

THE CHAIRMAN: I can see it for one company.

MR. WATSON: We set a period, I have forgotten what it was, but I think it was ninety days.

MR. DREWRY: Ninety days, and then in subsequent years about forty-five days.

MR. WATSON: We open the enrolment for ninety days. We have to close it after a while.



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THE CHAIRMAN: Why?

MR. WATSON: Because people will hold off joining until they know they have to go to the hospital next week, and then they join.

THE CHAIRMAN: Our period is from the 1st of May to the 31st of May.

MR. BERRY: If it is a compulsory plan. You could not have the kind of plan, a Government plan that would visualize people could come in and pay taxes, or premiums, whenever they wanted to. They must come in within a given time.

They cannot wait until, as Mr. Watson says, they are going to the hospital tomorrow and say now we start to pay the premiums. They must pay while they are well.

THE CHAIRMAN: They must pay it while they are alive.

MR. WATSON: These factors, sir, were presented with all the plans that were introduced. There was a period during which they must enroll. They could not enroll indefinitely, at any time and there was great trouble in British Columbia, if you will recall.

THE CHAIRMAN: You are saying that. I know that is not necessarily so in all Provinces. You may enroll at any time and your coverage starts thirty days after enrolment.

MR. KILGOUR: In a compulsory plan?

THE CHAIRMAN: In a hospitalization plan.

MR. WATSON: I am referring to a plan sir where there were premiums.



Drewry

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THE CHAIRMAN: This is a premium plan.

MR. DREWRY: Does it have a waiting period?

THE CHAIRMAN: Thirty days after enrolment.

MR. DREWRY: This is the same effect as requiring enrolment in a set period.

THE CHAIRMAN: No. What I am concerned about is citizen Jones who moved into the Province of Ontario from an area that really was not covered.

MR. BERRY: There would be a rule for such a case as that. That is where the individual has no control. If a person ceases to be a dependent, he then has the privilege to join himself at any time he wishes to become independent.

THE CHAIRMAN: Regardless of this mass enrolment?

MR. DREWRY: You cannot let anybody come or go as they see fit.

MR. WATSON: You were speaking of new residents? I was not referring to that type of situation. I was speaking of a resident who did not join but then subsequently decided to join. We would have adequate rules to take care of a new resident.

THE CHAIRMAN: Not only new residents, but you have new families.

MR. KILGOUR: People can buy coverage 365 days a year. This is, with many health insurance schemes, only available at rare intervals.

THE CHAIRMAN: No, I am talking about



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your program; this maximum premium business. In this regard you may not be able to answer this question. That is quite all right. You may not have the information. The program which was introduced in Ontario on a mass enrolment basis, covering everybody regardless of age or condition, advertised a certain premium. Now take the individual, how does that premium compare with your maximum suggested premium.

MR. KILGOUR: Slightly different sir.

THE CHAIRMAN: Lower or higher?

MR. STORY: If I may answer that sir.

The basic problem in comparison between the Association's premiums, which were given for illustrative purposes, and the premiums on the plan to which you refer, is that on the mass enrolment plan introduced in June in Ontario, it was handled primarily through the newspaper and for ease and simplicity, we chose two composite rates, one for people under fifty and one for people over fifty, so the Association plan would be lower in some instances and perhaps, according to the statutory maximum, would be fifty cents a month higher in other instances.

MR. KILGOUR: Really a very comparable range. It is natural one individual company would come out with a premium rate which did not concur precisely with this purely illustrative proposal.

THE CHAIRMAN: I suppose the program has not been in force long enough to have any experience. It would not be worthwhile discussing it as to utilization or excess cost of carrying it with the over-age group?

MR. STORY: Nothing that is sufficiently



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creditable, as yet. It has only actually had two months of claims sir.

COMMISSIONER VAN WART: Under the plan you visualize your premium is going to be an experience rating, or the overall Provincial pictures so to speak?

MR. WATSON: Are you speaking of the plan for the subsidized part that we are talking about this morning?

COMMISSIONER VAN WART: Yes.

MR. WATSON: This is an area we have not sufficiently canvassed because we put forth tentative proposals. If this principle of the master contracts that we were speaking of earlier for the medically indigent, remember; we are speaking of them. If that principle of master contracts was adopted, then we would consider they would have to be an experience rating although, of course, we cannot speak for other companies outside. This is merely our conclusion.

COMMISSIONER VAN WART: In that large group.

MR. WATSON: Of course, we cannot speak for all the companies at this time. This is merely a conclusion. Would you agree with that, Mr. Kilgour?

MR. KILGOUR: Yes.

MR. WATSON: Medically indigent group?

THE CHAIRMAN: Any condition, any age.

MR. WATSON: If you are speaking beyond the medically indigent group, then there would not be an experience rating, it would be operated on a totally different system. There the premium would be on the in-



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dividual risk, but the maximum statutory premium would be put in, and that premium would be put in a central pool and these losses would be assessed against the various companies. In a sense there would be rating, but it is not the true term to use.

THE CHAIRMAN: And the premium of the well person would be loaded to take care of this pool?

MR. WATSON: Yes. I am very glad you brought this out. In effect this proposal says we will cover people of all ages and no matter how serious their health, and in this group it is almost certain there will be an annual loss, and that annual loss is going to be spread over all the healthy lives. So this is, if you like, a device which will make it possible for people of advanced years and in poor health to be insured and have part of the cost spread back over the total insured population. I think that is quite an important point and is underlining the basic philosophy of this proposal.

MR. REID: Despite this loading on the healthy lives, it is affected very largely by competition. The whole field of health insurance, particularly in group and life insurance, is a very highly competitive one, to the point where I know our company cannot make any money, and I do not think anybody else can make much either.

COMMISSIONER GIRARD: Mr. Chairman, what kind of guidance will the individual get in purchasing his insurance? Supposing a man has a low salary and he wants to pay as much as he can and then he becomes ill and he cannot afford it, whereas if he had a small premium he would be able to carry it for a larger period when he



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is out of work. Is there any way in which a person could be helped in choosing the type of coverage which is more consistent with his revenue?

MR. WATSON: If I could try to reply to that. It is always difficult to give a specific answer when we are thinking of all sorts of Canadians in all walks of lives, but my thinking would be something like this. The majority of people in Canada today who are insured for medical care are either insured under group insurance plans which have been carefully worked out or they are in service plans. These are covering the majority of Canadians. The service plans are quite explicit, quite clear, they usually have only two choices and therefore the majority of people understand substantially well, and the premiums are of the order of not more than \$8.00 or \$10.00 a month.

Again referring to the medical care field for the family, a man out of work somehow or other has to get that premium paid.

COMMISSIONER GIRARD: I am talking about two families, where one family chooses to take the smaller coverage with the smaller premium and the other family chooses to take the larger premium, and they go out of work. One family is going to be able to carry on their premiums for a certain length of time without subsidization and the other family is going to have to get that subsidization immediately.

MR. BERRY: I think what you are saying very seldom happens. The man with a low income wanting to pay a very large premium is very unusual. We are



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4 talking about the man upon whom an agent must call. In
5 the first instance, the agent is not going to insist on
6 a premium that he cannot afford, and the company would
7 not have a large premium on a person with a low income.

8 COMMISSIONER GIRARD: I was taking
9 this out of my experience as a public health nurse going
10 into families with very small incomes and who had a
11 large T.V. set because they did not know how much they
12 were going to pay a week.

13 MR. BERRY: This is not true of in-
14 surance. They do not buy at all unless somebody comes
15 trying to get them to buy it.

16 COMMISSIONER GIRARD: If they bought a
17 smaller television set they could have kept up the payments
18 on it, and I was putting this in relation to insurance.

19 MR. WATSON: I think the comprehensive
20 plan, the illustrative plan would be applied to everyone.
21 He would be entitled to that, and I think the agents
22 would have to make a point of offering it to each person.
23 I think that kind of guidance would be implicit, because
24 there would be a responsibility on the companies that
25 that kind of instruction would have to be very exactly
26 complied with.

27 THE CHAIRMAN: Mr. Kilgour and gentle-
28 men, thank you very much. You have been very helpful to
29 us again, coming back in this way and having given time
30 to thinking over your original submission and ideas that
gave us difficulty. You have been very, very helpful.
Thank you very much.

MR. KILGOUR: Thank you very much, Mr.
Chairman.



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THE SECRETARY - Mr. Chairman, the next group is the Canadian Chiropractic Association. Their rebuttal submission will be numbered R-2, and Dr. Morgan will introduce the members of his group and he will read two short summaries which have been prepared and will be part of the record.

---EXHIBIT No. R-2: Rebuttal Submission of
Canadian Chiropractic
Association.

SUBMISSION OF THE CANADIAN CHIRO-
PRACTIC ASSOCIATION

Appearances: Dr. W. O. Morgan
Mr. J. S. Burton
Dr. D. C. Sutherland
Dr. D. W. Macmillan
Dr. W. R. M. Corrigan
Dr. R. Partlow

DR. MORGAN: Mr. Chairman, members of the Commission, my name is Wilfred Oliver Morgan; I am a practising chiropractor in Vancouver, and I am President of the Canadian Chiropractic Association. I would like to introduce my colleagues. On my left is Dr. Richard Partlow, Vice-President of the Canadian Chiropractic Association; next is Mr. J. S. Burton, legal counsel of the Canadian Chiropractic Association, from Vancouver; Dr. D. C. Sutherland, Executive Secretary of the Canadian Chiropractic Association, from Toronto; Dr. W. R. M. Corrigan, Past-President of the Canadian Chiropractic Association, and Dr. Donald Macmillan, from Toronto.



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THE CANADIAN CHIROPRACTIC ASSOCIATION

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SUPPLEMENTARY EVIDENCE

- 1 - Exhibit #28 - "Chiropractic in California and the
Nation", by Dr. Dewey Anderson
- 2 - Appendix #1 - Saskatchewan Press Reports
- 3 - Appendix #2 - Article from London News Chronicle.
- 4 - Appendix #3 - Article from Die Medizinische Zeitschrift.
- 5 - Appendix #4 - Book Review of "Radicular Syndromes with
Emphasis on Chest Pain Simulating Coronary
Disease", by David Davis, M.D.,
Howard University.



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Mr. Chairman and members of the Commission:

INTRODUCTION

1. The members of our profession, and particularly the members of our brief committee, have followed with keen interest the progress of this Commission as you have moved across Canada. Coincidentally there have been several serious problems arise in the health field in Canada and throughout the world, since the Commission was appointed, that emphasize the great need for the very type of study which you have undertaken. Our committee is pleased to extend its full co-operation to the Commission and your research staff in the furtherance of your investigations with a view toward helping to provide a high standard of health care for the people of Canada.
2. We have noted with approval the special interest which the Commission seems to be taking in the treatment of mental illness and also in the "compartments" that have ~~developed~~ in the health field. It is regrettable that one organization, with all of its special problems and interests, often fails to see the value in other organizations' activities. We are all inclined to view our particular area of endeavour as being of paramount importance while we relegate others to a second, third or fourth category. In actual fact, however, no one is in a position to stand in judgment of another's work if he does not have personal training and experience in that particular field. The decision as to the merits of any particular



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service must be left in the hands of those who have received the service, those who have provided it, and those who are charged with its administration, including the government department to which the group is responsible. For any one group in the health field to stand in judgment on another, with whose activities they may not be completely familiar and whose principles they may not fully understand, is not in keeping with our democratic form of government of which we are so proud.

3. We shall now deal directly with statements that have been made to the Commission and with material that has been presented in printed form. If some of our rebuttal comments appear to be quite critical these are not to be taken as indicating a lack of willingness to co-operate, but rather, as expressing our deep concern over certain monopolistic tendencies in the health field.

MONOPOLISTIC TENDENCY

Reference:

4. An example of this tendency occurred as recently as August 7, 1962, in Saskatchewan, when the Regina and District Medical Association urged the City Council to refuse the Regina Council of Chiropractors permission to use the civic health auditorium to conduct a one-day, pre-school clinic for children. The medical association explained its



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opposition in the following words, "it not only would be an insult to the medical profession, but also a wedge for the future attempts to undermine the medical profession", if chiropractors were granted the use of the auditorium.

Comment:

5. The wisdom of that statement was rightly questioned by Dr. M. A. King, President of the Chiropractors' Association of Saskatchewan, who pointed out that many prominent Regina citizens are patients of chiropractors and that their children would be examined in the clinic, that they were not interested in trying to undermine the medical profession, and that chiropractors and their patients, all tax-payers, have just as much right to use the civic auditorium which was constructed out of public funds, as any other group.

6. Dr. King also pointed out that not too many weeks previously, the medical profession had been in fear of losing its freedom through the establishment of the medicare program and had claimed that the government was trying to completely control the profession. "Now", he said, "the shoe is on the other foot. We have a complete reversal of the situation in which the medical profession wishes to control the chiropractic profession." Newspaper clippings of this controversy are attached as supplementary evidence.

Reference:

7. A further indication of monopolistic trends was seen when representatives of the Canadian



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Medical Association, appearing before the Commission in Toronto last May, and medical witnesses in Manitoba, in answer to a question from the Commission, stated in effect that they did not favour the inclusion of chiropractic care in a national health program.

Comment:

8. We take exception to this stand, and since the Canadian Medical Association has introduced evidence from sources within the American Medical Association, we wish to quote for the information of the members of the Commission, the policy adopted by the American Medical Association with regard to freedom of choice of practitioner. The basic freedom has been supported by men of stature in our North American democracies since the day our nations were founded and was well-stated by the American Medical Association through its House of Delegates in December, 1959, at Dallas, Texas. Its statement reads as follows:

9. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physicians and free competition among physicians as being prerequisites to optimal care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition".

10. This principle of friendly competition being utilized as an effective force in maintaining high standards is also recognized by the Canadian



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Medical Association. In its Journal of July 28th, 1962, in a report concerning the hearings of this Commission, the subject of mental health and the shortage of personnel is discussed. The appropriate sentence reads as follows: "Active, competitive practice in psychiatry was noted as essential for high-quality treatment."

11. Although this acceptance of the principle of active competition is intended to apply within the medical profession, we submit that if it is a requirement for the maintenance of high standards on the part of individual practitioners, it is just as vital in the development of new methods and techniques between the various professions in the healing art. Therefore medicine's desire to monopolize this field is not in the public interest. It would slow the advances in methods of health care which would otherwise be brought about through the spirit of competition, a force which medicine has accepted as "essential".

12. Sociologists recognize this need of competition in our modern society and the subject is brought sharply into focus by Walter I. Wardwell, Ph. D., Associate Professor of Sociology, University of Connecticut, in his paper entitled, "Public Regulations of Chiropractic". Journal of National Medical Association, March 1961, Dr. Wardwell writes:

13. "However, the real danger of monopolistic control by one 'school' of therapy is that scientific and technological advance may be stultified by orthodoxy. Many of the



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major forward strides of medical science have come not from practitioners or even from medical researchers but from the laboratories of non-medical scientists or from observant laymen. The distinctive contribution of chiropractic (and similarly of osteopathy) may represent another such forward stride which society cannot afford to lose."

14. Although openly subscribing to the principle of active competition, medical associations do not always adhere to this policy. Evidence of this is seen in the fact that the United States Court of Appeals for the District of Columbia, on October 12, 1942, found that the American Medical Association and the Medical Society of the District of Columbia were guilty of conspiring to restrain trade within their own profession in violation of the Sherman Anti-Trust Act. They had opposed the development of Group Health Association whose major purpose was to provide low-cost medical care on a prepayment basis. This is an example of "the real danger of monopolistic control by one 'school' of therapy..." cited by Dr. Wardwell.

15. The importance of competition between professions as well as between individuals is illustrated in the fact that while medicine, the senior profession in the healing art, has all but ignored physical methods, due to other rapid advances in its field; chiropractic, a young profession, has seen the need and has developed a new method of approach



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to many painful conditions with outstanding success and without any assistance. If this element of competition had not been introduced into the health field, it is doubtful if the importance of spinal mechanics as it is related to the role of the nervous system in influencing our everyday health, would have received any recognition. Chiropractic has made and continues to make a distinct contribution and deserves equal recognition and co-operation.

BASIC SCIENCE ACT REPEALED

16. In determining the role of the non-medical groups, care must be taken to see that their professional autonomy is preserved. A few years ago, in Manitoba, there was a requirement that chiropractors wishing to enter the province had to write a Basic Science Board. During the years in which this requirement was in force, it was felt that there was bias and discrimination in the manner in which it was administered. The Manitoba Chiropractic Association presented its evidence of this to the government with the result that the Basic Science Act was repealed in 1953.

17. Entrance examinations to-day are conducted by the Board of Chiropractors under the authority of the Chiropractic Act. We mention this fact here because further evidence of bias toward chiropractors by Basic Science Boards, and of surreptitiously increasing the grades obtained by medical applicants



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in the United States will be presented by our Ontario Division and the Board of Directors of Chiropractic of Ontario.

ORGANIZED OPPOSITION TO LEGISLATIVE
IMPROVEMENTS

Reference:

18. As a current example of the organized and unjust opposition which our profession has had to face over the years we would point out that the seemingly innocent suggestion by the College of Physicians and Surgeons of Ontario, to this Commission, that they should license chiropractors, has more serious implications than appear on the surface.

Comment:

19. The impression is created that this would be in the public interest because it would raise standards. However, the College of Physicians and Surgeons received a report from its solicitor in 1958 which recommended three possible courses of action which the College could follow in its constant battle against the chiropractic profession. One of these choices was for the College to: "adopt an 'all-out offensive' policy and seize the opportunity to give chiropractic in Ontario a 'knock-out' blow". One of the means of accomplishing this feat was by "attempting to elevate chiropractic to its own destruction...". This line of attack was shown to have fewer disadvantages than some of the others, while one of its



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chief advantages was that it created the impression that the College was showing concern in the public interest. Under these circumstances their desire to license chiropractors can hardly be looked upon by us as an offer of assistance.

20. The real concern in the public interest, is that such monopolistic tendencies, for destructive purposes, by those with a vested interest, must be opposed with all the force at our command.

21. Such offensive tactics thus displayed by organized medicine have been responsible over the years, for denying to our members in Quebec and Nova Scotia, the protection under the law to which they are entitled. It also has deprived the 1/3 of Canadians who are resident in those provinces, of the assurance of a controlled standard of health care; and of course it makes any legislative improvements in licensed areas serving 2/3 of Canadians, most difficult to obtain. Any effort to improve the health services available to Canadians must, of necessity, correct this undesirable situation.

22. This need is clearly pointed out in the paper entitled, "Public Regulation of Chiropractic" by Walter I. Wardwell, Ph.D., Associate professor of Sociology at the University of Connecticut who has this to say:

23. "Without a system of registration there can be no real control over standards of practice, for under such circumstances anyone (the author, for example!) can



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hold himself out to be a chiropractor without having to demonstrate his qualifications to practice.

24. " 'Bootlegging' chiropractic is not conducive to professional morale or to ethical conduct. If occasional chiropractors are abortionists or law-violators, as medical spokesmen suggest, and as some physicians are, a system of registration should aid in their detection. Once chiropractors have secured legal status they can be expected to want to safeguard it and to see that errant members of the profession are brought into line."

25. Toward the end of his paper, in speaking of the relationship between medicine and chiropractic, Dr. Wardwell writes:

26. "Only an open-minded judgment by disinterested persons over the long run can decide the question. As relations now stand between medicine and chiropractic it is highly unlikely that an impartial evaluation of the scientific and therapeutic merits of chiropractic can be obtained. Public policy demands, therefore, that layment (in this case the state) neither pre-judge the case nor abdicate their right to decide it. The wisest policy is to be as democratically permissive as the need for protecting the



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public's welfare will permit. Just as with conflicting ideologies or opinions on social policies, the only guarantee of attaining the best solution is to permit free and unbiased investigation of the facts and unhampered discussion of the issues. Scientific truth cannot be established by edict no matter how legally constituted the authority. The issue between chiropractic and medicine as systems of therapeutics can never be resolved by legal action or 'power politics' but must be settled on its merits. The best way to regulate the practice of chiropractic is therefore to permit chiropractors as much autonomy as possible consistent with protection for the public."

27. In our opinion, the aim of the medical profession is to establish medicine as the one and only form of health care, to relegate all other forms of care to medical control and administration. We submit, however, that medicine, even though the largest and most senior member, forms but one important branch of the health field.

28. The medical profession, after years of denying the principle and practice of chiropractic, is now intent on claiming it as part of medicine. Chiropractic is a necessary, separate branch of the health care field and not a part of medicine. The chiropractic profession will strongly resist all

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4 medical attempts to control and monopolize the
5 health field, particularly wherein chiropractic is
6 concerned. We suggest that the health needs of
7 Canadians will be best served through the continued
8 existence of separate and distinct branches of the
9 healing arts working together in friendly competition
10 and co-operation. We endorse the statement released
11 by the Commission and issued by the press following
12 the Toronto hearings, that, "No one phase of health is
the complete answer".

13 29. To conclude this point then, and in
14 keeping with our statement that chiropractic is a
15 separate and distinct profession, any new or amended
16 legislation must protect the public and the chiro-
17 practic profession from the constant efforts of
18 others to dominate or control. We must have pro-
19 fessional autonomy consistent with adequate pro-
tection of the public from unethical practises.

20
21 CHIROPRACTORS IN NATIONAL
22 HEALTH PLAN

23 Reference:

24
25 30. Medical representatives in Manitoba
26 have expressed to this Commission their objections to
27 the payment of fees for chiropractors' services under
28 a national health plan.

29 Comment:

30 31. This appears to be in conflict with



medical attempts to control and monopolize the health field, particularly wherein chiropractic is concerned. We suggest that the health needs of Canadians will be best served through the continued existence of separate and distinct branches of the healing arts working together in friendly competition and co-operation. We endorse the statement referred to by the Commission and issued by the press following the Toronto hearings, that, "No one phase of health is the complete answer".

To conclude this point then, and in keeping with our statement that chiropractic is a separate and distinct profession, we set on record legislation must protect the public and the chiropractic profession from the constant efforts of others to dominate or control. We must have professional autonomy consistent with adequate protection of the public from unethical practices.

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the views of the Government of Manitoba for in that Province chiropractors' services have already been included in the welfare program.

EXTENSION OF PRESENT SERVICES

Reference:

32. The Manitoba Government has also recommended to this Commission that the role of the "non-medical groups" be clarified and that they believe, "that the services of these recognized non-medical groups are important in any extension of health services."

Comment:

33. This view is not shared by the medical profession and is reflected in the policies of Trans-Canada Medical Plans where no provision is made for including chiropractic care. A large number of commercial insurance carriers, however, do provide the services of a chiropractor for their policy holders. Under these circumstances we would object to any suggestion that the control of a national health plan be placed in the hands of Trans-Canada Medical Plans. There must be an independent and impartial agency established which will not be subject to the monopolistic desires of organized medicine so that all necessary services, including chiropractic, will be provided for the consumer.



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"CHIROPRACTIC IN CALIFORNIA"

Reference:

34. "Chiropractic in California" is the title of a survey carried out by the Stanford Research Institute, by means of a grant provided by the Haynes Foundation of Los Angeles. The survey was released in 1960 and is in the hands of the research staff of this Commission.

Comment:

35. Our profession takes the most vigorous exception to interpretations which have been placed on this report by the American Medical Association who bought the report and circulated it to all state affiliates. A summary of this survey appeared in the Ontario Medical Review.

36. It has come to our attention that a member of the Commission's research staff, studying the chiropractic profession in Canada, also took part in the above-mentioned survey. This report caused consternation in the chiropractic profession because of the inadequate sampling which lead to erroneous conclusions. The report itself cautions the reader with regard to the adequacy of the sample and warns against drawing any general conclusions, however, this did not deter the American Medical Association from using the material in a manner for which it was never intended. We feel that this should be brought to the attention of this Royal Commission in order to avoid a repetition.



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5 report has been carried out by Dewey Anderson, A.B.,
6 M.A., Ph.D., (Leland Stanford University). Dr.
7 Anderson points out that the "Stanford Research In-
8 stitute is an independent corporation doing paid
9 research on contract, and not to be confused as a
10 part of Stanford University". He also says, "There
11 is a marked halo effect surrounding this survey as a
12 product of a university of such high reput as Stan-
13 ford. But the faculty and scientific schools of that
14 institution had nothing officially to do with it".
15 Much of the work done by the Stanford Research In-
16 stitute is on contract, with the findings becoming the
17 property of the person or organization paying for it.
18 This was the case with the chiropractic survey which
19 was ordered and paid for by the Haynes Foundation."
- 20 38. There are two aspects to this survey
21 which we would like to comment on briefly at this
22 time. Dr. Dewey Anderson's study of the survey will
23 provide additional information and we shall make it
24 available to the Commission as supplemental evidence.
- 25 39. Point number one concerns the validity
26 of the survey insofar as it can be counted on to
27 portray accurately the types of conditions treated by
28 chiropractors. The survey itself warns the
29 reader that the small sampling and the wide dis-
30 tribution of chiropractors makes the results un-
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tended and has used the figures to point to the decline of chiropractic. The fallacy of this interpretation is seen clearly when one realizes that in sampling the opinions of patients in the Los Angeles area, Santa Clara County, and the San Francisco-Oakland area, only 1.2 patients were represented for every 100 chiropractors. That is an average of one one-hundredth of a patient for every chiropractor. On this sample, in spite of the cautionary statements in the survey, the medical profession attempts to arrive at conclusions which will be helpful to them in their campaign against our profession.

40. Point number two concerns the reported decline in the number of chiropractic graduates which has been used by the A.M.A. to further its campaign. The survey reports that from 1930 to 1957 the total number of chiropractors per 100,000 population dropped 25%. This has been used unjustly to point to the decline of the profession. Dr. Dewey Anderson, following his study of this survey report, has this to say:

41. "The parallel with medicine is close on on this point of institutional upgrading, and its effects upon numbers of practitioners too. For if the period under review went back to the 1910-20 era, following the disclosures of the Flexner Report on medical education, it would be seen that even at that late date diploma



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mills and institutions so inferior that they were incapable of training reputable and qualified MDs characterized the education available to medical doctors. "Abraham Flexner's research on medical education conducted for the Carnegie Foundation condemned medical education in the United States as unworthy, a hazard to the sick, and declared that over three-fourths, or 120 of the then existing medical schools, should be closed as unfit to train physicians. When the American Medical Association adopted its standards and classification system for medical schools, enrolments declined one-half and the number of medical doctors licensed dropped for a period of time as the new standards began to have their effect. But the condition was not permanent and did not presage any early demise of medicine as a profession."

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Dr. Anderson further points out that,

"The trend has now been reversed. The record shows that by comparing State Board figures, 11 more chiropractors were certified in California in 1960 than in 1956."

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The expansion programs being carried out by at least four of the chiropractic colleges in the United States in recent years, plus the expansion program we have commenced in Canada is certainly not



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PHYSIOLOGICAL BASIS OF CHIROPRACTIC

Reference;

45. The physiological and anatomical basis for chiropractic has been challenged many times by orthodox medicine and once again we find that this viewpoint has been included in the Noble report to the College of Physicians and Surgeons of Ontario, a report which has been submitted to this Commission by the Canadian Medical Association.

Comment:

46. We wish to state that such preconceived notions have no basis in fact. This matter of the physiological basis of chiropractic will be rebutted in greater detail by our Ontario Division since the report originated in this province. It will be sufficient for us to mention now that the most recent and up-to-date investigations into the activity of the nervous system are substantiating the chiropractic position. We refer to the following research and

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publications:

47. (1) Dr. Hans Selye, University of Montreal has been hailed as the "greatest doctor since Pasteur". He is investigating the role of stress as a common factor in producing many diseases. Dr. R. F. Farquarson, Professor of Medicine at the University of Toronto, is quoted as saying that if Dr. Selye's theories are proven clinically, "it will be one of the great discoveries of medicine.
48. Selye himself has said, "I doubt if the field we have been working in (endocrinology) is any more important than the nervous system. If a new and ingenious way of translating the activity of the nervous system could be found it would be a great thing."
49. As chiropractors, we have been emphasizing the role of the nervous system for many decades and were therefore interested to note in a report about Dr. Selye's work, that his theories of a common cause for many disorders gave a new value to the views of chiropractors.
50. (2) Russian research into the activity of the nervous system has long been of interest to our profession. The work of A.D. Speransky, Director of the Department of Patho-Physiology of the Institute of



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Experimental Medicine U.S.S.R., was published in 1943 in a book entitled, "A Basis for the Theory of Medicine". His book holds that the nervous system is intimately involved in the production of pathological processes and thus closely parallels the work of Dr. Selye. Both studies lend support to the views long held by chiropractors.

51. (3) The Department of Health, Education and Welfare of the United States Government recognizing this new development, recently published a book entitled, "Soviet Medical Research Related to Human Stress." After discussing the work at Soviet research centres, similar to that done by Speransky, the U.S. Government summary makes this comment, "These approaches could serve to point out significant phenomena which have been largely overlooked in the West."

52. In order to establish that this subject has not been entirely overlooked, in the West, and to demonstrate that there is a continuing flow of articles from authoritative sources which uphold the value of chiropractic methods and principles, we submit the following as supplementary evidence:

53. (a) Article from London News Chronicle.
(b) Article from a German medical magazine, "Die Medizinische Zeitschrift".



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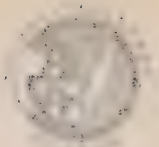
(c) Book review of "Radicular Syndromes with Emphasis on Chest Pain Simulating Coronary Disease", by David Davis, M.D., Instructor in Medicine, Harvard University

This book by Dr. Davis explains how the symptoms of visceral disease can originate in the spine. Although he confines his studies to the symptoms of coronary disease, other organs and systems of the body receive nerves from the spine and are subject to the same influences.

CONCLUSION

54. In our previous submission to this Commission we outlined the role played by the chiropractic profession in the health field in Canada. We dealt at some length with the relationship between the medical and chiropractic professions and explained that although differences of opinion are depriving some people of the health care they require, we are ready and willing to co-operate with all other professions in improving the health services available to Canadians.

55. We are most deeply concerned, therefore, to note the antagonism and reluctance to recognize the services of others which has been exhibited by the medical representatives when questioned regarding the roles of other health care professions. The report prepared for the College of Physicians and Surgeons of Ontario by Mr. W. H. Noble, and subsequently



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56. Surely it is the responsibility of each of the professions to recognize the authority of government in the licensing and regulating of the various professions, and to co-operate with licensed members of those professions in the public interest. Without the active support and co-operation of all branches of the healing art and all levels of government, any effort to improve the health services available to Canadians will fail to attain its full potential. The chiropractic profession in Canada, herewith pledges its support.

59. The Canadian Chiropractic Association is grateful for this additional opportunity to comment on health services in Canada. We do appreciate the co-operation shown our profession and the members of our delegation by the Commissioners and staff of this Royal Commission and we pledge our continued co-operation in the programs designed to improve the health of Canadians.

Respectfully submitted,

W. O. Morgan, D. C.,
President,
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Can't use civic health centre AUGUST 8, 1962

Chiropractor issue boils up

City aldermen became engaged in a lively debate Tuesday night during a regular council meeting as to whether the chiropractors of Regina should be allowed use of the civic health auditorium for a one-day pre-school clinic.

The debate started when letters were received from the Regina and District Medical Association and Dr. Frank Jackson, medical health officer, recommending the building not be granted.

While the recommendation was upheld, council at the same time voted in favor of offering the chiropractors the city transit system building in which to conduct a clinic.

A letter from the Regina and District Medical Association said a recent resolution passed by the association considered it "not only an insult to the medical profession, but also a wedge for the future attempt to undermine the medical profession," if the

auditorium was granted to the chiropractors.

Commenting on the issue, Ald. D. K. MacPherson said "this entire thing is getting a bit ridiculous."

"I don't see why such emotions should arise if another body uses part of the clinic."

Ald. Les Sherman said the schedule of the building would not be upset because "there is nothing happening in it on Saturdays. The Workman's Compensation Board recognizes

a chiropractor's certificate and so do a number of insurance companies.

"Therefore I see no harm would be done in allowing them to use the building for one day," he said.

Ald. Jim Dutton suggested council back the recommendation by the medical health officer "because he is getting paid good money to make such decisions." The matter was settled when

Ald. Joseph Wilkie suggested council back the recommendation, but at the same time make another building like the transit building available to the chiropractors.

Dr. J. B. Mesher, president of the Regina and District Medical Society declined comment as to why the medical profession would be "insulted" if chiropractors were allowed to carry out a one day clinic in the auditorium.

Chiropractors irked by doctors, council

An official of the Chiropractors' Association of Saskatchewan Thursday charged city council was aiding medical doctors in refusing chiropractic health care for the children of Regina.

The accusation was made by Dr. Mark A. King, president of the association, and also president of the Regina council of chiropractors.

"Medical doctors are definitely refusing chiropractic health care for children. City council is aiding this by following a recommendation from the Regina and District Medical Association to refuse chiropractors usage of the civic health auditorium to conduct a one-day pre-school clinic," Dr. King said.

Asking the medical association to explain its letter to council Tuesday night which said, "it not only would be an insult to the medical profession, but also a wedge for the future attempts to undermine the medical profession," if chiropractors were granted use of the auditorium, Dr. King said:

"Where does the insult come in? There are many prominent citizens of Regina who are patients of chiropractors. Would the medical profession be insulted if those people send their children to the clinic?"

"The association said it would be insulted if we were granted the auditorium. However, chiropractors feel insulted by council agreeing with that association," he said.

Although council decided not

to grant permission for the auditorium, chiropractors were given the green light to hold a clinic in the city transit system building.

CLINIC CANCELLED

However, because of the lack of proper facilities, Dr. King said the offer would be turned down and the clinic cancelled.

"A few weeks ago the province was involved in a medical care crisis, in which the medical association claimed it was losing its freedom and the government was trying to completely control the association," Dr. King said.

"The doctors claimed no gov-

ernment was qualified to control the medical profession. Now, the shoe is on the other foot. We have a complete reversal of the situation in which the medical profession wishes to control the chiropractic profession," he said.

"Nobody wants to undermine the medical profession, because it is a necessity of life," he said.

Dr. King pointed out the civic health centre was built with public funds, "and therefore I don't see why other organizations promoting a health program cannot use the building. We all are taxpayers."

AUGUST 11, 1962

Chiropractors lose again in bid for health centre

City council by five votes to four Tuesday night denied to Regina chiropractors use of the civic health centre for a back-to-school spinal check-up clinic. Alternate accommodation has been offered for the one-day clinic.

In the debate which preceded the vote, most council members appeared to favor accommodating the clinic in some city building but not specifically in the health centre. They felt this particular accommodation was being made a cardinal point in the antagonism of medical doctors towards chiropractic and did not wish to take a side in the issue.

The majority vote of five against granting use of the health centre to the chiropractors was by Aldermen Jim Dutton, Chris Pedersen, Ian Forbes, Joe Young and Joseph Wilkie. Voting for Ald. D. K. MacPherson's motion to grant use of the centre were Aldermen Les Sherman, Vince Matthews, Mayor Henry Baker and the proposer, Ald. Fred Mullin and Ald. Jack Pearl were not at the meeting.

Dr. R. W. Hamilton, a member of the board of directors of the Chiropractors' Association of Saskatchewan, who addressed council on behalf of the association's Regina physical fitness committee, told Ald. Matthews that all members of the association were certified by an examination board headed by the dean of medicine of University of Saskatchewan.

To Ald. MacPherson, Dr. Hamilton said the chiropractors did not seek accommodation other than in the health centre since the citizens had built that for community health.

Ald. Sherman said reports of the previous council meeting did not state that the seven-member attendance that night had been four-to-three against the health department recommendation to deny chiropractors use of the health centre.

Ald. Young said it was not a matter of being for or against chiropractors. The council had a motion recorded, after the issue arose last year, that any decision in this matter be for the health department.

Mayor Baker said council was still the supreme authority.

Ald. MacPherson moved and Ald. Sherman seconded a motion that permission be given for a clinic in the health centre.

Ald. Dutton moved and Ald. Wilkie seconded an amendment that council's previous delegation of authority in the matter to the health department be rescinded.

After some discussion on whether council should first vote on rescinding the old motion delegating authority to the health department, Mayor Baker ruled the vote would be taken on the Ald. MacPherson's present motion and the result was five-four defeat.

AUGUST 21, 1962

UNFAIR

The Editor: Well it should be very obvious to the people now, wherein the blame for all the grief over medicare, should rest. The "medicare men," have once more struck their true colours, in the dispute with the chiropractors, over leasing the civic health centre for one day.

Who and where in God's green earth, have the doctors the almighty right to set themselves above all else, professional or otherwise? Possibly they feel that it was this city council, that we're presently blessed with.

That's another thing. Where does city council get off, by refusing taxpayers citizens the right to lease a building built with public funds? The doctors have built themselves a little kingdom, onto themselves, and now aided and abetted by various groups, Ross Thatcher and his Liberals, and now our city council, they seem determined to see how far they can promote this anarchy. I suggest that it is about time the people stood up in resounding vocal protest, and let them know just where the end of the line exists.

DON CRIGHTON

Regina ★ ★ ★

AUGUST 11, 1962

SEGREGATION

The Editor: Segregation has reared its ugly head in Regina. Because the Regina and District Medical Association objected to the Chiropractors using the civic health auditorium for a one-day pre-school clinic, on the ground that it would insult the medical profession, the chiropractors were denied its use by city council.

This professional snobbery was upheld by city council who backed the adverse recommendation of the city medical health officer, himself a doctor and therefore unlikely to give an impartial decision.

If department heads are paid to make decisions of policy like this why do we need aldermen? Mayor Baker said chiropractors have every right to the use of that auditorium as a clinic, and as the auditorium would be vacant on the day it was required council's decision is an appalling example of bias, or worse.

Regina F. EDWARDS

Health centre on agenda

The agenda posted in city hall for council's regular meeting at 7:30 p.m. Tuesday promises a some further discussion on use of the Civic Health Centre by chiropractors.

Council recently acceded to a protest from Regina and District Medical Association, and a recommendation from the City health department, that chiropractors be refused use of the health centre for a September one-day pre-school clinic.

Council offered use of the city transit building instead but the chiropractors indicated they would turn this offer down on the grounds of lack of facilities there.

The matter is on the agenda for Tuesday's meeting under the heading—delegations—and with the note "Regina physical fitness committee re use of Civic Health Centre for back-to-school spinal check-up clinic."

The issue is not new—last year council allowed use of the health centre, going against a city health department recommendation, and brought a minor storm on its head from medical interests.

Two debenture bylaws are mentioned for discussion. One bylaw is for \$258,000 for electric light and power extension and a second is for \$800,000 for a boiler for the electric light and power plant.

There are ten items under the heading city commissioners' reports. These concern such matters as tenders, licences, and quotations and also the monthly reports from each department of the city administration.

Items under communications and petitions number six and one by the city solicitor concerning the protest by four residents against the community health centre being allowed to establish at 2363 McIntyre street.



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APPENDIX #2 - Pg. 17B

British M.D.'s Rapped

For
Failure to Assess
Chiropractic;
Funds Wasted
Medical
Correspondent Says
in
London Newspaper

LONDON, England. (ACP)—The London News Chronicle, in an article titled "How Blind Can Doctors Be," said, "It is fantastic that no serious attempt should have been made by the medical profession to assess the results of osteopathic and chiropractic manipulation in cases of acute and chronic backache."

Excerpts from the article by the newspaper's medical correspondent follow:

"A patient with acute backache has a poor chance of getting better quickly with the treatment generally available under the Nationalized Health Service. This is my experience as a G. P., and many people who have had 'slipped discs' or have 'strained their backs' will bear me out.

"... Thousands of patients with backache, under whatever label—slipped disc, lumbo-sacral strain, lumbago—after trailing from G. P. to hospital and back to G. P. go eventually to an osteopath or chiropractor outside the N.H.S., are manipulated and get better. The situation is ludicrous.

"... Only a handful of doctors use these methods and, if they do, are regarded as cranks or worse by their orthodox colleagues.

"... Listen to Sir Reginald Watson-Jones, the distinguished orthopaedic surgeon, speaking about spinal manipulation at the Royal Society of Medicine in October last year: 'It is a harmful procedure no matter what the source of the low back pain may be.'

"To be fair to Sir Reginald, he went on to stress the undoubted dangers of spinal manipulation in unskilled hands.

"But that is not an argument against all spinal manipulation. It is only a reason for seeing that it is never performed without first making quite sure that there is no underlying disease which manipulation can make worse. Obviously

only a doctor, using X-rays, can be sure about this. (More than 80% of members of the British Chiropractors' Association possess their own X-ray equipment. The remainder have X-ray facilities available.)

"Yet what happens at present?

"A labourer slips and strains his back. He can neither walk nor stand without pain. His G. P. sees him and puts him to bed for a week with hot-water bottles and aspirin. At the end of that time, as he is not much better, he is given a note to attend an orthopaedic clinic. After some time he gets an 'appointment.'

"There the surgeon has him X-rayed and diagnoses a 'slipped disc' (he calls it a P.I.D., or prolapsed intervertebral disc) and puts the poor fellow in a most uncomfortable contraption called a plaster jacket. This almost immobilises his spine and reduces his pain, but he still cannot work.

"So far he has cost us all quite a lot of money in treatment and sick benefit.

"Worse is to come. After a month the plaster jacket is removed and he is given an expensive corset, reinforced with steel, specially made for him. He still cannot walk normally. He is instructed to attend the physiotherapy department three times a week and a 32 horsepower ambulance with a crew of two carries him to and from the hospital. After six weeks of this his acute pain has gone, but any attempt at labouring work brings back all his symptoms.

"What does he do? He returns to his family doctor, who may well admit that he can do no more. He may also scribble the name of an osteopath (or chiropractor) on a scrap of paper and push it across his desk, mumbling something like 'Don't say I sent you.'

"Whether his N.H.S. doctor sends him or not, our patient with backache frequently ends up at an osteopath or chiropractor, who clears up his symptoms . . .

"At the clinic of a well-known chiropractor . . . I met three doctors' wives having treatment. One was brought by her husband . . .

German M.D.'s Report 'Fantastic' Chiropractic Results

Translated in part from the German medical magazine, "Die Medizinische Zeitschrift," which also reported on the finding of spinal abnormalities in 86 of 100 ulcer patients.

IT BECOMES more and more apparent that clinical medicine, especially internal medicine, pays too little attention to vertebral variations . . . and we believe it behooves every responsible physician to draw therapeutic consequences from these new findings.

The application of Chiropractic, of course, will be indicated in almost every case because we will always find a vertebral involvement. Proof for this can only come with time. It would be wrong, on the other hand, to give up completely the old proven methods for a not entirely proven theory.

We originally adjusted a group of patients, mostly women, suffering from headaches, shoulder-arm syndrome and lumbago. We were amazed to find that abdominal pains of various types—of which these patients had complained for many years — had disappeared without trace.

We then took patients who suffered from specific internal diseases and adjusted them in the involved dorsal area.

So far we have not found one case which failed to respond to some extent.

The results often are so fantastic that the patients believe in a miracle, and one can understand this after having been under medical care for years without results.

We believe out of personal experience that good Chiropractic must have an influence over the entire vegetative system above and beyond the local influence.

We come now to the question of Chiropractic care of stomach ulcers and various other visceral cases with spinal involvement. We must, after our experiments and research, join entirely to the idea of Gutzeit, namely, that changes in the dorsal spine, especially in diseases of the viscera, play a very important pathogenic part in

diseases of the viscera. We have drawn out of these findings some therapeutic consequences.

We are often inclined to speak of real visceral disease only when we detect definite morphological findings.

Almost all nerve interference produced by the spinal column leads to functional disturbances in the viscera, which we cannot detect immediately with our present diagnostic procedures.

Only the heart presents the opportunity for a thorough functional diagnosis by the electrocardiograph, but it is also possible to correct heart disturbances by adjustment of the cervical vertebrae.

Misalignment in the dorsal spine could be the cause of visceral disease, but the misalignment also could exercise only a localized influence and certainly would not constitute the only pathogenic momentum. A typical dorsal spine subluxation can cause the building up of calculi in the kidney and gall bladder.

Abnormal tonicity and mobility, and hindered drainage (most easily seen in X-ray) lead to inflammation and this, together with changes in the composition of the products to be excreted, leads to formation of calculi.

The stomach ulcer is another example of the localized influence of abnormalities in the dorsal spine. To accept only a vertebral factor in the etiology of the stomach ulcer is not a disputable question as far as we know now. A known malfunctioning of the vegetative system brings about a definite change in the vascular system prior to the development of the ulcer.

Add to that exogenous causes such as psychic factors which besides bringing about stomach malfunction also add capillary damage.

Since the vegetative and vascular abnormalities in stomach ailments are of general nature and not limited to the stomach, it has been a question for many years why abnormalities lead to ulceration only in the stomach and duodenum. Only in these organs can one attach a pathogenic factor to the acid juices when conditioned tissue cells are heavily damaged by nutrition.

That nerve interference brought about in the dorsal region has an influence on the production of a stomach ulcer through the vascular system is indicated by the research of F. Dittmar, who says that very marked vascular changes are produced in the outer coat of the stomach. The research of Kroll and Rein indicate the same findings.

According to Bartsch, skeletal changes may cause vegetative-vascular irritation and thereby become blood vascular reflex mechanisms.

In considering any of several visceral ailments, one has the impression that the supplying blood vessels, the tonicity and vitality of the organs are affected by changes in the dorsal spine.

Rickers considers changes in the nerve channels as the primary cause of disease. Is the stomach ulcer a typical example of Rickers' neuro-pathological trend? Development of the actual ulcer occurs at the end of a series of functional disturbances which include the hormonal factor.

These disturbances are in reciprocal influence with intermingling nervous and hormonal factors.

But all extra-vertebral and extra-gastric etiological factors cannot account for a stomach ulcer.

When one succeeds in interrupting these disturbances emanating from the dorsal region, all other etiological factors in relation to stomach ulcers are without effect.

Harvard Researcher's Findings Parallel Chiropractic

MEDICAL practitioners and researchers are producing a growing tide of evidence and opinion which, whether they know it or not, supports the plain and simple truths of Chiropractic.

David Davis, M.D., an instructor in medicine at Harvard University and a former research fellow at Beth Israel Hospital, describes his "discoveries" in a recently published text: "Radicular Syndromes With Emphasis on Chest Pain Simulating Coronary Disease."

Dr. Davis' findings on nerve involvement greatly parallel those of Dr. D. D. Palmer, who launched the science of Chiropractic on similar premises some 60 years ago.

Official medicine for many years scoffed at the idea of nerve pressure or impingement at the intervertebral foramina. The American Medical Association still ridicules Chiropractic because of competitive economic reasons but honest university researchers continue to confirm the importance of the nervous system in health and sickness.

Unlike the two German M.D.'s who reported "fantastic" Chiropractic results (see March and April Reviews), Dr. Davis apparently made no attempt to adjust patients showing the symptoms he describes. Following are excerpts from his text:

*** Recognition of a disorder demands its consideration in differential diagnosis, and this is especially important in dealing with the causes of chest pain. While in over 90 per cent of cases chest pain is due to coronary disease, spinal root compression or a psychogenic disturbance must be considered if errors are to be avoided.

Once one becomes alerted to the (spinal) root-chest pain syndromes, root compression will be found to be one of the common causes of chest pain. Illustrating its incidence when a cardiologist is well aware of it, is Ollie's report of 197 cases in a survey of 600 consecutive patients complaining of chest pain. The fact that it so often simulates various manifestations of coronary disease makes it particularly important in differential diagnosis.

In the vast majority of cases, root compression results from faulty body mechanics, postural or occupational strain and trauma, which, in time, cause the soft tissue and bony changes of osteoarthritis of the spine. Degenerative disk disease with or without protrusions, spurs about the posterior vertebral margins and the interarticular joints, deformities of the root pouch or fibrosis of the root sleeve are conditions that most commonly produce root irritation with chest pain. Primary neoplasm of the spinal cord and meninges and metastatic lesions from such primary sites as the prostate, lungs or gastro-intestinal tract may also be responsible for root compression and these sources must be considered in diagnosis.

A rough idea of the possible role of some of those factors can be obtained from plain roentgenology and sometimes more exact information from myelography. The age, occupation, presence or absence of trauma, type of onset, duration and severity of symptoms and signs and their response to therapy give some information as to the probable character of the lesion.

Frykholm's studies show that compression of the ventral motor

roots produces pain in the distribution of the muscles supplied by these roots and this type of pain differs in character from that due to dorsal sensory root compression. Motor root pain is usually dull, gnawing, aching, continuous and more localized. Sensory root pain is intermittent, sharp, stabbing and frequently radiates down the upper extremities. Another form of pain, more superficial in character, most often described as a tingling or "pins and needles" sensation, and frequently associated with numbness of the hand and fingers, is also of sensory root origin. Motor and sensory root pain may co-exist.

Compression of lower cervical motor roots produces pain in the region of the serratus and pectoral muscles that are innervated by these roots. The skin of the chest wall and the intercostal muscles are supplied by the upper thoracic sensory roots. Therefore, chest pain may arise from either the lower cervical or the upper thoracic regions of the spine. The higher incidence of roentgen changes in the lower cervical spine in contrast to the upper thoracic spine suggests that the lower cervical roots are more often the cause of symptoms. The frequent occurrence of chest pain with motor root characteristics also suggests a lower cervical origin.

GENERAL CHARACTERISTICS OF ROOT PAIN: Chest pain due to root irritation may be mild or severe, sharp or dull, intermittent or prolonged, localized or widespread and occur with or without radiation. When severe it may simulate myocardial infarction, coronary failure, angina pectoris or pleurisy. More often it is the prolonged dull,



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constricting distress that arises from irritation of the ventral motor roots that suggests coronary disease.

Pain of spinal origin may occur over any part of the chest, in the back, on either side of the spine, in the axilla, in front over the breasts and subternally. Occasionally it radiates from sternum to jaws or neck region, where it may be felt as a choking sensation. Severe attacks may be accompanied by pallor and excessive perspiring. In some patients the chest pain is precipitated by walking, simulating angina pectoris. Many patients also complain of a peculiar respiratory distress characterized by an inability to breathe in or out. It may be associated with other cervical root symptoms such as shoulder girdle pain, occipital headache or vertigo.

CARDINAL CHARACTERISTICS AND DIAGNOSIS: In addition to the many features that suggest coronary disease, certain cardinal characteristics of radicular pain are usually present. Attacks frequently occur in relation to certain movements or postures, such as bending or turning or prolonged sitting in a crouching position, after coughing, sneezing, deep breathing or straining at stool and after hours of recumbency, often waking the patient from sleep. These relationships are not always volunteered. The patient has to be questioned to bring out this information and sometimes significant data are obtained only when subsequent attacks are observed.

ROOT PAIN SIMULATING MYOCARDIAL INFARCTION: The root syndrome may appear suddenly as an overwhelming attack of severe chest pain without any previous history to suggest a disorder of the spine. When such severe attacks are isolated or infrequent, the cardinal characteristics of the syndrome may not be apparent.

ROOT PAIN SIMULATING ATTACKS OF ACUTE CORONARY FAILURE: When root irritation is chronic, a patient may have innumerable bouts of chest pain lasting seconds, minutes or hours. With this number of attacks the cardinal features of radiculitis, namely, pain

in relation to recumbency, positions and movements, is more likely to be apparent and this information should suggest root disease. Early in its course, however, when attacks are isolated and few in number, these relationships may not be apparent and the attacks will closely simulate acute coronary failure.

ROOT PAIN ASSOCIATED WITH RESPIRATORY DISTRESS: Respiratory distress characterized by the inability to inspire or expire is a common manifestation of lower cervical and upper thoracic root compression. Approximately one-third of patients with chest pain of root origin complain of this type of distress at some time in the course of the illness. It occurs not only with the attacks of severe pain but sometimes without pain. Rarely it is a presenting symptom long before the onset of chest pain and attacks may be sufficiently severe and persistent to suggest erroneously cardiac asthma.

ROOT PAIN SIMULATING ANGINA PECTORIS: There are instances, fortunately few in number, in which a thoracic root syndrome may so closely simulate typical angina pectoris that differential diagnosis is extremely difficult. Early in its course the chest pain may occur only in walking or other exertion and be relieved quickly by rest. The type of pain may be identical in location, character and radiation with that of angina pectoris and its occasional response to nitroglycerin may be further misleading. Although it is seldom precipitated by excitement or cold, association with even these factors is occasionally made by patients.

When the pain is induced by walking or other exertion, it must be re-emphasized that the relation is not to cardiac work performed, but to certain spinal movements that increase root irritation. Each step in walking apparently causes a little jar to the spine, particularly when the patient assumes an exaggerated kyphotic posture. The absence of attacks in the same patient in the course of greater physical exertion points to a spinal factor rather than to angina pectoris.

EXAMINATION FOR SPINAL

TENDERNESS: Significant tenderness over the spine at the root lesion is almost an invariable finding when symptoms of root compression are present. In the cervical region the spine should be examined for tenderness over the spinous processes in back and over the transverse processes laterally. The upper cervical spinous processes can be readily palpated in most subjects if the neck is relaxed in a slightly extended position. The transverse processes can easily be felt with the finger tips on each side from just below the mastoid process to the angle of the neck and shoulder. Tenderness in this region is often present when there is none over the spinous processes in back. Examination for tenderness should be made in various degrees of head rotation, flexion and side bending.

Tenderness over the spinous processes can be elicited in the thoracic area with the ball of the thumb. In addition, the thumb is placed in the groove on either side of the spinous processes and pressure directed medially so as to twist the vertebra. This twisting maneuver will sometimes evoke tenderness and referred pain to the shoulder girdle or anterior chest that is not obtained by direct pressure over the spinous process.

In a study by the author of 100 patients with chest pain of root origin, moderate or marked spinal tenderness was present in 94 and the level of tenderness generally corresponded to the distribution of root pain.

REPRODUCTION OF REFERRED PAIN BY PRESSURE OVER THE SPINAL LESION: In 33 of 100 patients pressure directed over the vertebrae induced pain over the anterior or lateral region of the chest wall.

INDUCTION OR RELIEF OF SYMPTOMS BY MOVEMENTS: When a patient states that a specific body movement involving the spine induces chest pain or that pain can be relieved by a given body position, it should be reproduced and observed. When active movements do not induce pain, forceful passive movements may do so and should be tried.



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SECTION II

THE ONTARIO CHIROPRACTIC ASSOCIATION

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Mr. Chairman, Members of the Commission:

INTRODUCTION

1. The Ontario Chiropractic Association wishes to be associated with the presentations made to this Commission by the Canadian Chiropractic Association, the Canadian Memorial Chiropractic College and the Board of Directors of Chiropractic of Ontario, and we support their comments and recommendations.
2. In December and January of 1949 and 1950, The Honourable Mr. Justice W. D. Roach held hearings in Toronto to enquire into and report upon The Workmen's Compensation Act of Ontario. Our profession's representatives attended those sessions since we had been providing service under the terms of the Act since 1937.
3. The efforts of the medical profession to have chiropractic care removed from the provisions of the Workmen's Compensation Act, during the hearing, were defeated, and the Commissioner made it clear in recommending that our services be retained, that the Workmen's Compensation Board was not concerned with political rivalry between professions, but with the welfare of the injured worker.
4. The opposition to our services at that time was expressed by the delegate representing both the Ontario Medical Association and the College of Physicians and Surgeons of Ontario, the Registrar-Treasurer of the College of Physicians and Surgeons,



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Dr. Robert T. Noble.

THE NOBLE REPORT

5. Mr. Warwick H. Noble, Q.C., present solicitor for the College of Physicians and Surgeons, is the son of Dr. Robert T. Noble, and the tradition of hostility toward the chiropractic profession which has characterized the actions of the College in past years is being continued through his efforts. As solicitor for the College he is the author of a report entitled, "A Study of Osteopathy and Chiropractic", dated December, 1958.

6. This report has been submitted to this Commission in evidence by the Canadian Medical Association, and it is our understanding that the members of the Commission and staff have had an opportunity to read the report. We have no doubt that you will have recognized in this document the monopolistic desires of medicine in the health field and their unrelenting opposition to chiropractic for over half a century in spite of the fact that their 7 or 8 plans of attack have all failed in their basic intent, which is to eliminate the chiropractic profession.

7. The Noble Report, as it has come to be called, first came to our attention between two and three years ago. Since it has been submitted to this Royal Commission it is our intention to demonstrate that:



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(a) The reason for the report being ordered was not in the public interest, but to thwart chiropractic attempts to improvement in legislation.

(b) It is laden with inaccuracies, incorrect assumptions, misleading statements; all of which are used to support a preconceived and prejudiced opinion.

8. If the Commission wishes a detailed reply after we have answered the major issues raised in this report and demonstrated the inaccuracies and bias therein, which calls into question the veracity of the entire document, this could be prepared at a later date.

9. A few words on how the Noble Report came to be written will be appropriate at this time. In 1957 the Ontario Chiropractic Association arranged, through its Legislative Committee, for a new Act to be presented to the Department of Health through the offices of the Board of Directors of Chiropractic of Ontario. This was to be entitled the "Chiropractic Act", similar to acts in other provinces, and it would remove our profession from the Drugless Practitioners Act. This latter act is not appreciated by our profession, or by the osteopaths or by the physiotherapists, all of whom are under its regulations. We believe that each of these organizations has communicated this thought to this Commission.

10. The Ontario Chiropractic Association went to considerable trouble in the preparation of this new act. Our Committee worked for a period of about



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three years in its preparation. All chiropractic legislation in North America was studied by our committee and a cross-indexed review of this legislation was prepared composing some 124 pages. This has been submitted to the research staff of this Commission. From this review we drew up new legislation which incorporated the best features of all the other acts and which would provide a high standard in the interests of both the public and the profession. The new act was approved by both the Ontario Chiropractic Association and the Board of Directors of Chiropractic, and was presented to the Department of Health in 1957.

11. For many long months we wondered why no action was being taken and why there were not even enquiries for further information or for discussions on certain of the items included in the act. The document seemed to have disappeared from view.

12. About two years ago we had the opportunity of perusing a report that had been prepared for the College of Physicians and Surgeons of Ontario by their solicitor, Mr. Warwick H. Noble, Q.C. It became quite obvious on reading this report that the College of Physicians and Surgeons had studied our recommendations and had instructed their solicitor to report on them. He was also instructed to prepare a report for the College on chiropractic so that they could be guided in determining what their future policy would be toward our profession. Having received the opportunity to read this document, quite unexpectedly,



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we studied it carefully.

13. In our earlier presentation to this Commission we made no mention of this report as it was prepared for the College of Physicians and Surgeons of Ontario on their instructions. We did, however, deal in a more general way, with the relationships that have developed over the years between the medical and chiropractic professions. We stated that much of the difficulty is due to misunderstandings and mis-information and that medical views on the subject of chiropractic have changed drastically.

14. The principal origin of such misunderstandings is to be found in reports such as that submitted to this Commission by the College of Physicians and Surgeons of Ontario. As mentioned earlier, this report came to our attention about two years ago and it was designed to thwart any improvements in chiropractic legislation in Ontario.

15. We shall now demonstrate, as briefly as possible, the bias that is present and the inaccuracies that characterize the Noble Report.

16. In the preface it states that this is to be a "factual study". The author then goes on to say: "Although authorized to obtain the assistance of others in the preparation of this report, I found that it was impracticable to do so, other than by way of clerical assistance, and I have myself assembled, analyzed and organized the material and prepared the text of this report". He then goes on to express his indebtedness to several medical organizations and



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we studied in carefully.

In our earlier presentation to this

Commission we made no mention of this report as it was prepared for the College of Physicians and Surgeons of Ontario on their instructions. We did, however, deal in a more general way, with the relationship that have developed over the years between the medical and chiropractic, osteopathic, etc. It stated that much of the difficulty is due to misunderstanding and mis-information and that medical views on the subject of chiropractic have changed drastically.

The present origin of such misunderstandings is to be found in reports such as that submitted to this Commission by the College of Physicians and Surgeons of Ontario. As mentioned earlier, this report came to our attention about two years ago and it was designed to show any improvement in chiropractic legislation in Ontario.

As stated in our memorandum, as printed in the preceding pages, the view that is present and the

in the present it states that this is to be a "factual study". The author then goes on to say: "Although neither led to nor in the assistance of others in the preparation of this report, I found that it was fundamental to do so, other than by way of clerical assistance, and I have myself assembled and organized the material and prepared the text of this report". He then goes on to express his indebtedness to several medical organizations and



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committees in the United States of America for sending information.

17. Although this was to be a factual study using whatever assistance was necessary, we find that apart from obtaining a calendar of the Canadian Memorial Chiropractic College, and attempting to distort the meaning of some of the statements found therein, the author avoided the Toronto headquarters of the Canadian Chiropractic Association, the Ontario Chiropractic Association, the Board of Directors of Chiropractic and the Canadian Memorial Chiropractic College, all of which were readily available to him and all of which could have provided the factual information which is completely lacking in his study.

18. A survey of a profession cannot be effectively conducted without the co-operation of the profession concerned, yet Mr. Noble decided for reasons best known to himself, that it was, to quote his own words, "impracticable to do so."

19. The fact that we, the only ones who could provide the accurate information concerning our profession, were not even advised of the preparation of this report, speaks louder than any words we might say.

20. In commenting upon this document in their Annual Report for 1958 -59, the College of Physicians and Surgeons states; "An exhaustive study assembling all available information has been made by the College solicitor and copies have been distributed to those most directly concerned."

21. This report was neither an "exhaustive



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study" nor did it even attempt to assemble "all available information." In fact the sources of such information were deliberately avoided. A few of the reasons for the unacceptability in toto of this report will be seen as we now deal with a number of statements made by the author in the order in which he presented them.

22. Reference:

On page 2 the author refers to "dogmatism and cultism" as being the greatest foes of reason and science and states that, "a little truth is a dangerous thing".

23. Comment:

He ably substantiates these views by his own ignoring of the facts and his willingness to colour the truth with an abundance of misinformation.

RESPONSIBILITY OF THE COLLEGE OF PHYSICIANS AND SURGEONS

Reference:

24. On page 3 and in other parts of the report it is said that the original intention of the government was to have the College of Physicians and Surgeons responsible for all those who administer to the needs of the sick.

Comment:

25. This supposition is refuted by the actions of the government of this province and other provinces, wherein many different pieces of legislation have been passed dealing with those who administer to the sick,



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since the establishment of the College of Physicians and Surgeons and these various groups have not been placed under the jurisdiction of the medical profession. The Government itself is responsible for the regulation of the various professions and certainly no one professional group, with a vested interest, should ever be granted the privilege, which rightfully belongs in the hands of the government, of supervising the affairs of other professions.

26. In addition to these points, we find in the Report of the Baruch Committee on Physical Medicine, April, 1944, that such groups as ours are referred to as being "non-medical". In our brief to this Commission we have pointed out that medical authorities have stated that spinal manipulation was not taken into the fold of orthodox medicine. In view of these facts we fail to see by what quirk of logic the College of Physicians and Surgeons claims that they should be responsible for licensing of chiropractors; a group whose basic premise they have ridiculed since the very beginning.

MEDICAL EDUCATION

27. Reference:

On page 3, paragraph 1, reference is made to the long course of study and clinical experience required of medical registrants.

28. Comment:

This statement is made with reference to the period just preceding 1906, and since it implies



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that medical education of that period was satisfactory in comparison with chiropractic education, we would like to refer the Commission to Abraham Flexner's report on medical education in 1910 which was prepared for the Carnegie Foundation for the Advancement of Teaching. In this report it was recommended that 80% of the medical schools in United States and Canada be closed in order to raise educational standards. In fact over 50% of them were closed as a result of this study. Henry S. Pritchett, President of the Foundation, in his introduction to Flexner's report has these comments to make on the status of medical education in that period;

29. "The significant facts revealed by this study are these:

- (1) For twenty-five years past there has been an enormous over-production of uneducated and ill-trained medical practitioners. This has been in absolute disregard of the public welfare and without any serious thought of the interests of the public. Taking the United States as a whole, physicians are four or five times as numerous in proportion to population as in older countries like Germany.
- (2) "Over-production of ill-trained men is due in the main to the existence of a very large number of commercial schools, sustained in many cases by advertising methods through which a mass of unprepared youth



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is drawn out of industrial occupations into the study of medicine.

(3) "Until recently the conduct of a medical school was a profitable business, for the methods of instruction were mainly didactic. As the need for laboratories has become more keenly felt, the expenses of an efficient medical school have been greatly increased. The inadequacy of many of these schools may be judged from the fact that nearly half of all our medical schools have incomes below \$10,000, and these incomes determine the quality of instruction that they can and do offer.

"Colleges and universities have in large measure failed in the past twenty-five years to appreciate the great advance in medical education and the increased cost of teaching it along modern lines. Many universities desirous of apparent educational completeness have annexed medical schools without making themselves responsible either for the standards of the professional schools or for their support."

30. This summary of Flexner's conclusions adequately describes the environment into which chiropractic colleges were born at the turn of the century. When the author of this report to the College of Physicians and Surgeons deplores the fact that early



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chiropractic colleges were operated for profit, we feel it necessary to point out to the Commission that this very charge was laid at the door of the medical colleges of that day, with the recommendation that 80% of them be closed. As a direct result of these disclosures, millions of dollars have been poured into medical colleges, much of it by governments, to assist them in overcoming their difficulties. Not one dollar, however, has been available to chiropractic colleges. We have elevated our standards by the efforts of the profession alone and we bear a heavy burden to-day, in financing the operation of our colleges. Our Canadian educational institution is incorporated as a non-profit, professionally-owned college, and receives financial support for operation only from the profession itself.

31. The Canadian Medical Association Journal of December 2nd, 1961, in an editorial, stated: "Many tend to forget how recently the profession purged itself of the grossest elements of inadequate education, charlatanism and unethical professional practices. The profession has largely lifted itself out of the pre-Flexnerian mire by its own bootstraps".

32. We submit that those "bootstraps" were reinforced by gold thread made from government funds and other sources.

LEGISLATION

Reference:

33. Reference is made on page 10 to "limited

University of California, Berkeley, California, 94720
Dear Sirs:
I am writing to you in regard to the information that
this very thing was said at the heart of the matter
colleges of that day, with the recommendation that
30% of them be closed. As a direct result of these
discussions, numerous colleges have been forced to
medical colleges, such as it by an attempt to transfer
them in over the years. I am sure that one of the
however, has been unable to do so. I am sure that
We have tried to set standards by the efforts of the
profession alone and we have a hard time doing so.
In fact, the question of the colleges of
California educational institutions is important as a
non-profit, professional, and educational institution.
Financial support for operations only from the state
is not enough.

of December 1961, 1962, in an attempt to do so.
to be to report how recent the profession guided
of the present situation of the educational
organization and method of professional education.
The profession has long been faced with the fact that
information is by its own nature, and
to admit that these "professional" were
supported by the state and the government funds
and other sources.



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practitioners" and the statement of the American Medical Association that "limited practice acts are almost impossible to enforce satisfactorily."

Comment:

34. We would like to go on record as stating that we do not desire to extend our scope of practice into the medical field and that we consider ourselves fully licensed to perform the functions which our legislation describes. Our license can only be viewed as "limited" if one is considering that we are a branch of the medical profession. However, since our profession developed outside of medicine and has had to struggle against opposition from medicine, one can hardly claim with any justification, that we form a part of that profession. It is certainly our desire to see that we have professional autonomy and control and that our members have the use of facilities that are required to enable us to provide the highest possible standard of service, in the public interest, within our own field of activity.

35. In reply to the statement of the American Medical Association referred to above, that "limited practice acts are almost impossible to enforce satisfactorily", we have provided letters in Appendix 1 from several governmental authorities who have made comments on this subject. We believe these expressions from government officials effectively refute the American Medical Association's statement.



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INACCURATE AND UNJUST USE OF HISTORICAL REFERENCES

Reference:

36. On page 35 Mr. Noble quotes an American physician, Dr. Boyd, who states: "the theory generally holds that all diseases and illnesses are due to one cause, namely a slight dislocation or subluxation of one or more of the spinal vertebrae."

Comment:

37. This same argument has been presented in Nova Scotia whenever our profession was engaged in attempting to obtain legislation in that province. However, we have not made any such claim. This idea is imported from the United States from sources associated with the American Medical Association. They have quoted early chiropractors who did make such statements and imply that the same views are held by the modern chiropractor. We might just as well argue that the views held by some medical practitioners at the turn of the century are still typical of medical opinion to-day. One statement is just as ridiculous as the other.

38. Another erroneous remark in this document which endeavours to relate modern chiropractic to the practices of the pioneers, has to do with the comment by the President of the Palmer School of Chiropractic, when he said that he was in the business of manufacturing chiropractors. The author of the report states that this was said in 1950; however, Dr. Boyd, whose writings were used as a source of information by the



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author, says that this occurred in 1920, just a few years after the Flexner report which condemned medical schools for the same reason. We take the strongest possible exception to this digging up of chiropractic history while failing to relate it to medical history which exhibits the same problems.

39. It is significant that the author, on reviewing the calendar of the Canadian Memorial Chiropractic College and noting the books used in the course, chose to read the original book written in 1910 by D. D. Palmer, the founder of the profession. The obvious reason for including this book in the college course is because it is the principal work written by Palmer. There are other more up-to-date books listed in the calendar, one of which we have submitted as an exhibit to this Commission, but Mr. Noble makes no mention of more up-to-date data. He preferred to read those publications which would give him support in his preconceived viewpoint. This is indicated in the fact that he credits American medical sources for assistance in providing data for his report, while he makes no mention of having read modern chiropractic literature or having sought information from the many sources available to him right in Toronto.

Reference:

40. Another misleading point on page 39 deals with a requirement in proposed legislation in the State of New Jersey, wherein it is stated that if the new act were passed, those already in practice would



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be required to take a two-day post-graduate course to obtain their license.

Comment:

41. The author makes light of a two-day course as indicative of the amount of new information available, but pointedly refrains from saying that this two-day course is an annual requirement to assure that the registrants make an effort to keep up-to-date in their field. In Ontario, our association has been giving very serious consideration to recommending a similar requirement in this province, and although a two-or three-day course may not be considered extensive, it is two or three days longer than is required of the medical practitioners for renewal of license.

"LICENSURE HAS BECOME SHEER MOCKERY."

Reference:

42. On page 40 great stress is laid on the fact that many chiropractors are practising illegally. It takes issue with the National Chiropractic Association for protecting these practitioners.

Comment:

43. It is highly significant that the author has chosen for his examples, the States of New Jersey and New York. In New Jersey chiropractors are supposedly licensed by a Medical Board on which there is one chiropractor. The result is that few if any members of our profession are licensed.

44. In New York, of course, there is no



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4 legislation in spite of annual attempts by the State
5 chiropractic association to obtain legislation for the
6 past thirty years against strong opposition from the
7 medical profession. Even if a chiropractor or a
8 physician passed the examinations presently available
9 in the State of New York, he could not be licensed
10 to offer chiropractic treatment because there is no
11 legislative act in New York to establish such a license
for anyone, no matter how acceptably trained.

12 45. In elaborating on this point, the author
13 states that "licensure has become sheer mockery".
14 It is indeed ironic that the author should have
15 selected New York State as his example in this instance,
16 because during the past year an investigation has
17 been underway in that State following the discovery
18 that there have been gross irregularities in the
19 licensing of physicians. A probe of The State Board
20 of Medical Examiners was announced on July 28th, 1961,
21 by the State Education Department following the alleged
22 irregularities in the examining and licensing of
23 physicians. It was announced on May 25, 1962, that
24 the Board of Regents would cancel the licenses of 25
25 physicians because licensing examination grades had been
26 raised surreptitiously. 150 such cases were in-
vestigated but action was not contemplated in more
than 25 cases.

27 46. Two physicians have been found guilty of
28 conspiring to sell the questions and answers to state
29 licensing examinations. The secretary of the State
30 Board of Medical Examiners, who resigned at the time of



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the investigation, is awaiting trial and a fourth physician has pleaded guilty and is awaiting sentence, as of May 12, 1962. One of the physicians whose license was cancelled is a son of one of the members of the board. There could hardly be a greater mockery of licensing regulations than that displayed by the New York State Board of Medical Examiners, yet Mr. Noble has used this very State as his example.

BASIC SCIENCE BOARDS AND LEGISLATION

Reference:

47. We are pleased indeed to see Mr. Noble referring to Basic Science Boards on page 39 and stating that chiropractors have had difficulty in some instances in passing these Boards.

Comment:

48. In addition to the evidence presented above concerning irregularities in the licensing of physicians, in New York, there will be evidence presented by the Board of Directors of Chiropractic of Ontario to the effect that the identity of those writing Basic Science Board examinations has been obtained by improper means and that Chiropractors because of their known identity, have been failed in examinations which they actually passed, while physicians have been passed in examinations in which they actually failed. It will be seen from these facts, that statistics from Basic Science Boards are influenced by illegal acts designed to hinder the growth of the chiropractic profession. The Basic



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Science Act in Manitoba was repealed in 1953 when our practitioners claimed there was prejudice shown.

49. The same unregulated situation prevails in Quebec and Nova Scotia as exists in New York. Now this is not the result of any lack of effort or desire on the part of our profession. We have presented the case for chiropractic legislation year after year in these areas only to find that the vigorous opposition of organized medicine defeats our purpose. In spite of the fact that 87% of the States and Provinces have passed regulatory chiropractic laws, the public in the other 13% are denied the protection of such legislation. This lack of control makes it possible for unqualified persons to enter the area and open practice. The responsibility for this most undesirable state of affairs rests squarely with the representatives of organized medicine. As long as the medical profession is permitted to assume a position of such influence that it can deprive the chiropractic profession and the people it serves, of their rightful protection under the law, and can cause governments to fail in their duty, which is to see that only qualified practitioners serve the people, then it can surely be said, that, quoting Mr. Noble, "licensure has become sheer mockery". When medicine says that chiropractors should not be licensed in the remaining four States and four Provinces it is setting itself up as a supreme authority denying the value of the laws that have been passed by 87% of the august legislative bodies in North America.



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UNIVERSAL DECLARATION OF HUMAN RIGHTS

50. We feel that the Universal Declaration of Human Rights, adopted by the United Nations General Assembly on December 10, 1948, has an application in this situation. This Declaration states that everyone has the right to free choice of employment, all persons must have equal protection of the law, and none of their rights may be denied them because of some status beyond their own control. We have selected our area of employment by becoming members of the chiropractic profession - a licensed branch of the healing arts. According to the Declaration our members are entitled to equal protection under the law, as are the citizens who are their patients. This right of equal protection may not be denied them because of some status beyond their control. We find that these rights are not granted. Some of our members whose tuition was paid by the Department of Veterans Affairs of the Federal Government are unable to obtain a license to practice in their home provinces of Quebec and Nova Scotia and the citizens of these provinces do not benefit from the chiropractic legislation which protects two-thirds of Canadians. Because there is no license available for these members, they are frequently charged with practising medicine without a license when in actual fact they are not practising medicine. Colleagues who graduated with them enjoy legal status in other provinces so that there is not equal protection under the law. Also the un-



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4 licensed status of practitioners in Quebec and Nova
5 Scotia is a status over which they have no control
6 since they are willing to write examinations for
7 licensure but there are none available. Citizens
8 who travel from province to province are not afforded
9 equal protection under the law with respect to their
10 health care, as in most provinces our profession is
11 regulated by law but in Quebec and Nova Scotia it is
not.

12 51. We recommend to this Commission that the
13 Federal Government should recommend to the provincial
14 governments concerned; principally Quebec and Nova
15 Scotia, but also Prince Edward Island and Newfoundland;
16 that they take the necessary steps to pass chiropractic
17 regulatory legislation in keeping with the Acts in
18 force in other provinces; and that any professional
19 advice with respect to the preparation of such
20 legislation should be sought from the provincial
21 chiropractic association with assistance as requested
22 from the Canadian Chiropractic Association, and not
23 from representatives of organized medicine.

24 ADVERTISING

25 Reference:

26 52. On page 42, paragraph 2, the author looks
27 askance at the advertising done by some chiropractors
28 and blames this publicity for the fact that, "the
29 chiropractors have succeeded in completely over-
30 shadowing the physio-therapists in public acceptance".
On page 55 however he refers to the; "differences in the



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educational standards and training qualifications prescribed for chiropractors and physio-therapists".

Comment:

53. We feel that although some chiropractors have advertised in a manner not approved by our association, that this cannot hope to compete with the extensive advertising done for the medical profession by drug companies and others, on TV, radio and in the newspapers. Advertising has relatively little to do with the public's acceptance of chiropractic. The real reason lies in the author's admission that chiropractic education and training qualifications are set at a higher level than those of the physio-therapist. The method of treatment is quite different from that provided by the physio-therapist and is highly effective in many disorders. These facts, and these alone are responsible for our profession's success in, as Mr. Noble put it, "completely overshadowing the physio-therapist in public acceptance."

54. One additional factor of course is to be found in the short period during which the average physio-therapist remains in practice. An average of three years in practice after graduation, which was reported to this Commission, must surely mean that there are very few physiotherapists in practice who possess a suitable degree of experience. Nothing can substitute for experience gained in practice and without this experience physiotherapists are at a great disadvantage.

55. As Mr. Noble points out, the public has



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4 been turning to the chiropractic profession. This
5 is due to the effective service that the well-trained
6 and educated chiropractor is providing in his community,
7 with years of experience behind him and cannot be
8 blamed on a few newspaper advertisements which the
9 College of Physicians and Surgeons of Ontario would
have you believe.

10 Reference:

11 56. The matter of advertising is again
12 mentioned on page 42 when the author quotes Ontario
13 Regulations 214/44 which gives the Board of Directors
14 of Chiropractic control over advertising by registrants,
15 and he is critical over the fact that enforcement has
not been very effective.

16 Comment:

17 57. He fails to mention at this point,
18 however, that these regulations were replaced by
19 Ontario Regulations 37-8/55. When these were passed
20 in 1955 our Board was advised that the previous re-
21 gulations governing advertising had been revoked be-
22 cause the Act did not provide for such regulations.
23 This deprived the Board of the control which the author
24 states they had. He makes no mention of this fact
25 although he knew of the later regulations because he
refers to them a little further on.

26 58. For seven years, since 1955, the Board of
27 Directors of Chiropractic of Ontario, encouraged by
28 the Ontario Chiropractic Association, has striven to
29 obtain a suitable replacement for the previous ad-
30 vertising regulations. An exchange of views with



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the solicitor of the Department of Health over the years produced no results. When this delay was brought to the attention of the present Minister of Health, he acted promptly to amend the Drugless Practitioners Act so as to provide for the passing of a suitable regulation. We anticipate that this will be accomplished in the very near future. Why it should take seven years of exchanging opinions between our Board and the Department to obtain such obviously necessary control is beyond our powers of comprehension and while the author of this report makes quite an issue out of advertising control, he says not a word about our unending difficulties in obtaining it.

59. It is well known that regulations under the Act from the only effective means of dealing with such problems. This is recognized by the College of Physicians and Surgeons itself in their annual report for 1958-9 where they state under the heading of "Advertising": "Pressure to observe our Rules and Regulations will have to be kept up as we still have graduates in medicine who are just starting practice and who have not taken the trouble to familiarize themselves with our Rules and Regulation." In other words, it is not the professional integrity of the individual that causes him to avoid advertising, it is the Regulations that make it illegal for him to do so, and these we have been striving to obtain. The telephone books of such cities as Montreal and Chicago are examples of areas where medical advertising may be



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found, probably because the Regulations are not so strict.

BUSINESS OR PROFESSION

Reference:

60. On pages 45 and 57 it is stated that chiropractic is operated as a business rather than as a profession.

Comment:

61. This remark is brought to the present from words spoken by one of the original chiropractors so we have another example of an out-dated reference. We have already dealt with the business aspect of medical education and practice in the early part of this century as outlined in the Flexner report. However, if the author wishes to repeat this point for emphasis, let us refer, not to historical medical activities, but to the practice of medicine to-day. The author has used New York State as one of his examples, so let us turn our attention again to that area.

62. In addition to finding that unqualified persons were being licensed in medicine in that State, as referred to earlier in this submission, Mr. Augustus J. Bardo Jr., director of the State Education Department's Division of Professional Conduct, says: "We have evidence of doctors conspiring with lawyers to submit false claims, exaggerating medical reports, submitting bills for treatment not administered, and

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listing x-rays that were never taken." In a report release to the press on April 5th, 1962, the Department revealed that it was investigating such unethical acts on the part of 1,500 physicians in New York City, approximately one medical practitioner out of every twelve in the area.

63. On September 7, 1961, the Buffalo Evening News carried a report from New York worded as follows:

64. "Fourteen New York City physicians and one dentist were disciplined in connection with the State Board of Regents' investigation into a multi-million-dollar ambulance-chasing racket, it was disclosed today.

"Augustus J. Bardo, Director of the Division of Professional Conduct of the State Department of Education, said that 300 doctors and dentists throughout the State, mostly in the New York Metropolitan area, are being investigated."

65. It seems that in 1961 there were 300 investigations and in 1962 there were 1,500. One could continue to cite other references at some length dealing with unethical business practices by professional persons, but perhaps what has been said will suffice to show that human frailty seems to afflict all walks of life.

PHYSIOLOGICAL BASIS FOR CHIROPRACTIC

Reference:



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66. Now we come to what may well be the most important point in this presentation. It has to do with medicine's misunderstanding of the basis of chiropractic. On page 46, the author quotes from a chiropractic booklet published some years ago in which it is stated that: "The principles (of chiropractic) are based on accepted physiological facts and current research findings of recognized authorities". The author refers to this as a "startling statement": and says, "The medical profession and the author would welcome elaboration of the statements in the final sentence."

Comment:

67. It is not our intention to elaborate on the current research findings at this time, since we have included examples of this work in our brief to this Commission as well as in many of the 27 Exhibits which have been filed and copies have been provided to the medical association. We do, however, wish to point out that chiropractic procedures are based on physiological fact, a point which seems in doubt in the author's mind, and a doubt which has been communicated to this Commission, by those who submitted this report in evidence.

68. This viewpoint is also expressed in a booklet which the author has quoted extensively, published by the Louisiana State Medical Society of the American Medical Association. This book has been used to fight the application for regulatory chiropractic legislation in Louisiana, so you will under-

1875 Morgan

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practic legislation in Louisiana, so you will under-



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stand why it presents the negative side of the case only. The book was written by C.E. Boyd, M.D., of Shreveport, Louisiana who states on page 63, in a paragraph wherein he attempts to discredit chiropractic theory; -

69. "We further know that the spinal nerves have relatively little to do with the function of the internal organs such as the heart and lungs."

70. This statement which has been distributed for public information, by the American Medical Association, is false!

71. It is a shocking state of affairs to witness an organization having the tremendous influence of the American Medical Association, permitting a statement such as this to be used in their announced campaign of opposition to the chiropractic profession. The statement is false from the standpoint of elemental neurology and physiology.

72. In order to demonstrate this we refer the members of the Commission, and your research staff to pages 939 and 943 of the fourth edition of the book: "The Physiological Basis of Medical Practice", by Best and Taylor; a University of Toronto text in applied physiology. On the aforementioned pages this text thoroughly refutes the statement that:

"the spinal nerves have relatively little to do with the internal organs."

73. Best and Taylor show that the nerve cells which receive impulses from and send impulses to, the



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stand why it presents the negative side of the case only. The book was written by C.E. Boyd, M.D., of Shreveport, Louisiana who states on page 65, in a paragraph wherein he attempts to discredit chiropractic theory: -

"We further know that the spinal nerves have relatively little to do with the function of the internal organs such as the heart and lungs."

This statement which has been distributed for public information, by the American Medical Association, is false!

It is a shocking state of affairs to witness an organization having the tremendous influence of the American Medical Association, permitting a statement such as this to be used in their announced campaign of opposition to the chiropractic profession. The statement is false from the standpoint of elements of neurology and physiology.

In order to demonstrate this we refer the members of the Commission, and your research staff to pages 939 and 943 of the fourth edition of the book: "The Physiological Basis of Medical Practice" by Best and Taylor, a University of Toronto text in applied physiology. On the aforementioned pages this text thoroughly refutes the statement that: "the spinal nerves have relatively little to do with the internal organs."

Best and Taylor show that the nerve cells which receive impulses from and send impulses to, the



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internal organs via the sympathetic system, are located in the posterior root of the spinal nerve and in the spinal cord, respectively. The only way that nerve fibres from these cells can reach or influence internal organs is THROUGH THE TRUNK OF THE SPINAL NERVE.

74. Nothing further. Lest someone should suggest that the autonomic nerves function independently of the spinal centres because of certain routine reflex functions that take place, we quote the following from Best and Taylor's section on: "The Functions of the Autonomic Nervous System":

75. "The term autonomic as applied to the system is not altogether suitable since, as we have seen, it is under the control of centres within the central nervous system, and cannot function as an independent unit".

76. It is clear from these facts that the central nervous system, the brain and spinal cord, control the functions of the internal organs. It is also clear that the only path over which nerve impulses can travel from the spinal cord to the viscera, is through the trunk of the spinal nerve, the very structure which is said to have:

"relatively little to do with the internal organs."

77. Dr. Boyd also makes the erroneous statement that the nerves cannot be disturbed by misalignments of the vertebral column except in the case

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ment that the nerves cannot be disturbed by misalignments of the vertebral column except in the case



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of fractures or serious injury. This is a repetition of the view of Dr. Morris Fishbein expressed in 1932 and again in 1946. We have already thoroughly discredited this viewpoint in our brief by referring to medical authorities who have found that misalignments do occur and that they do irritate the spinal nerves. Nothing further needs to be said at this time.

CHIROPRACTOR AS EXPERT WITNESS

Reference:

78. On page 47 paragraph 6, of the Noble report, the author challenges our statement that chiropractors have been accepted as expert witnesses in courts of law.

Comment:

79. Such a statement serves to indicate the lack of thorough investigation that preceded the writing of the Noble report and thoroughly discredits it as an authoritative document. We quote for your information, part of a judgment issued in the city of Toronto in the case of Weaver vs. Carpenter - Toronto Jury - April 23, 1952 - before the Honourable Mr. Justice Anger.

80. We quote Mr. Justice Anger as follows:
"It is common knowledge that in the passage of years the science of chiropractic has greatly grown, and the same thing is true of osteopathy. It is common knowledge that frequently medical doctors refer patients in particular cases



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it as an authoritative document. We quote for your
information, part of a judgment issued in the city of
Toronto in the case of Weaver vs. Carpenter - Toronto
July - April 25, 1922 - before the Honorable Mr.

We quote Mr. Justice Aker as follows:

"It is common knowledge that in the
passage of years the science of chiro-
practic has greatly grown, and the same
thing is true of osteopathy. It is

doctors refer patients in particular cases



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to one of those practitioners for special treatment.

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"I do not think I need to elaborate to indicate that chiropractic and osteopathy have their place in our world to-day, and that both of those practices are sciences specially developed along lines which experience has indicate to be wise. It is common knowledge that those who enter into those vocations receive long, special and thorough training.

82.

"The witness (name) has already given evidence as to the study of anatomy over four years in the Canadian Memorial Chiropractic College in Toronto and that such study involved the whole of the anatomy including all the bones, the nerve structures and the rest of the human body.

83.

"I think it would be very wrong for me to rule that a chiropractor should not be allowed to give evidence as to what he found when a patient is brought to him for examination and treatment. I therefore decline to exclude that evidence...."

84.

"I therefore rule that the chiropractor may give his opinion as to what he found."

.....

85.

"I think in view of what was said, it is best to add these words; whenever any person gives evidence as an expert he



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should obviously confine himself to what is really in his field. We do not know what the answers of (the witness) are going to be. It may be that in giving those answers he may depart from what would appear to be within the field of chiropractic. In such a case I have no doubt the defence counsel will object, and I would myself. It is obvious, however, that a chiropractor can give much evidence of what he found, particularly with regard to bone structure, that is well within his field, and in regard to which he does become a real expert."

86. Additional evidence proving the acceptance of chiropractors as expert witnesses in courts of law is included in Appendix 11 for the information of the Commission. The first case listed is that of Roberts et al vs Valvasori, in the Supreme Court of Ontario, heard before the Honourable Mr. Justice Kelly in St. Catharines, Ontario, May 19, 20 and 21, 1952.

87. We believe that any person reading a report such as that prepared by Mr. Noble, who is a solicitor, would be entitled to expect that any reference to the legal acceptance and recognition of the parties under discussion would be accurately recorded, however, this is not the case here. Not only have we been able to demonstrate gross inaccuracies in those areas of the report dealing with the chiropractic profession itself, but now we find that the



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which he has become a real expert."

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of chiropractors as expert witnesses in courts of law
is included in Appendix II for the information of the
Commission. The first case listed is that of Roberts
et al vs Valasek, in the Supreme Court of Ontario,
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Catherine, Ontario, May 19, 20 and 21, 1921.
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author, whose specialty is law, has no knowledge of the chiropractor's legal position as an expert witness. He has apparently not taken the trouble to investigate this topic, yet has no hesitancy in implying that we are not so recognized. Such an attitude suggests a complete lack of the normal investigative procedures, thus placing the entire report in the category of hearsay evidence and biased opinion.

88. It has also been decided, by the Supreme Court of British Columbia, that medical evidence is not sufficient to show negligence on the part of a chiropractor. In such cases it is necessary that a chiropractor give evidence to this effect. We refer you to two examples of such a decision:

Cawley vs Mercer, 1945, 3 W.W.R., Page 41
Rutledge vs Fisher, 1939, found, W.W.R.,
page 494.

CHIROPRACTIC OUTSIDE OF NORTH AMERICA

Reference:

89. On page 47, paragraph 7, the author labels as false a statement that chiropractors are licensed in foreign countries. The World Medical Association is then quoted to the effect that "chiropractic is practically unknown outside of North America".

Comment:

90. Certainly chiropractic is better known in North America than it is in other parts of the world because the profession had its beginnings and its development here. To say that is "practically



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unknown outside of North America", however, is false.

91. Our Canadian college has welcomed students from Switzerland, Denmark, Germany, Britain, South Africa, Australia, Pakistan, France.

92. The European Chiropractic Union has affiliated groups in most European countries and supports a research centre in Geneva. The European convention drew about 40 Canadian chiropractors to Geneva this past summer.

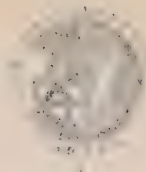
93. A chiropractic college is being planned for Britain and our Canadian college has been asked for assistance and advice in establishing the new institution.

94. A Royal Commission was appointed in Western Australia to study chiropractic among other groups and their report indicated that a sufficient percentage of the population depended on chiropractors' services that legislation should be enacted and an educational institution should be established for training chiropractors.

95. A Bill has been presented to provide for the licensing of chiropractors in the Republic of South Africa.

96. Legislation has been passed in Switzerland, New Zealand, Puerto Rico.

97. It would appear that the statement by the World Medical Association is an exaggeration.



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MEDICINE'S "LINE OF ATTACK" AGAINST
CHIROPRACTIC.

Reference:

98. On pages 52 and 53 we see that the College of Physicians and Surgeons has had its solicitor study the amendments we proposed to the Drugless Practitioners Act.

Comment:

99. This study was made without our knowledge and for the purpose of determining how the College of Physicians and Surgeons could best thwart our progress as a profession. This lack of faith and common decency, exhibited by the secret studying of another profession's requests, with the intent of planning ways and means of defeating the granting of such requests, is a prime example of the battle that has been fought over the years, thus wasting time and effort that could be better spent in planning for improved health services for the people.

Reference:

100. Under the heading of "The Alternatives Available", Mr. Noble lists three possible approaches which should be considered by the College of Physicians and Surgeons of Ontario. These three courses of action are shown in the form of questions as follows:

- (1) Should the College adopt an 'all-out offensive' policy and seize the opportunity to give chiropractic in Ontario a 'knock-out' blow?"



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(2) Should the College adopt a policy of 'partial offensive' and not only oppose the changes asked for by the chiropractors, but counter with changes that it considers desirable within the framework of the present legislation?'

(3) Should the College adopt a policy that is purely defensive and seek only to prevent any changes in the present legislation?",

Comment:

101 We have not been officially informed by the College, which course of action they intend to follow, nor do I suppose that we shall be. However, since they have suggested in their brief to this Commission that they should be responsible for the licensing of chiropractors, we can surmise that they have chosen the first plan, namely: "to give chiropractic in Ontario a 'knock-out' blow".

102. The author of the report points out that under this plan there would be two alternatives. The first would be to debase chiropractic to the level of physiotherapy ("debase" is Mr. Noble's word), where patients would have to be referred by a physician. Such a situation exists in the insurance program for Canada's civil servants and referrals under that program are almost nil. This would be a fine way to place a profession in a position where you can ensure its demise. It is admitted that this attack would not likely succeed as the public would not accept it

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(2) Should the College adopt a policy of 'partial offensives' and not only oppose the changes asked for by the chiropractors but counter with changes that it considers desirable within the framework of the

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The author of the report points out that under this plan there would be two alternatives. The first would be to create a separate board for the first level of physiotherapists (designated as 'first level' word). Where patients would have to be referred by a physician. Such a situation exists in the insurance program for Canada's civil servants and referees under that program are almost nil. This would be a fine way to place a profession in a position where you can ensure its future. It is assumed that this attack would not likely succeed as the public would not accept it



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and it ignores the higher educational qualifications of the chiropractor.

103. The second alternative under the 'knock-out' program is described as an "attempt to elevate it (chiropractic) to a status that will ensure its eventual destruction. This alternative had fewer disadvantages listed by Mr. Noble ~~than~~ any other of his "lines of attack". Medicine knows from its own experience that courses of study that are too long and expensive can result in discouraging young people from enrolling. They have been experimenting in their own field by shortening some courses in an endeavour to overcome this problem. Experience would seem to show that a health care profession's standards could indeed be elevated, supposedly in the public interest, to the point where young students would seek entry into courses in engineering or other fields.

104. One of the advantages of this second alternative, to quote Mr. Noble, is that it "indicates a concern for the best interest of the public."

Surely using the public interest as a smoke screen, a deceptive device, for delivering a "knock-out blow" to a licensed profession is sufficient reason for not granting the request of the College of Physicians and Surgeons of Ontario, when they suggest that they be given the privilege of licensing members of the chiropractic profession.



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TRAINING OF CHIROPRACTORS

Reference:

105. Their complaint before this Commission that our graduates are "engaged in the practice of medicine poorly trained, without adequate instruction in the basic sciences....." is not based on fact.

Comment:

106. Our graduates are engaged in the practice of chiropractic, well-trained and receive adequate instruction in the basic sciences. For example our graduates are passing examinations set by the University of Saskatchewan for entry into that Province.

107. The College of Physicians and Surgeons of Ontario has never agreed with the licensing of chiropractors in this Province, as is clearly set out in the review of their activities by Mr. Noble. There have been six or seven different "plans of attack" from approximately the year 1900 to 1946, all of which were intended to end the practice of chiropractic in this province. In 1923 when they thought they had accomplished their goal, Mr. Noble tells us: "The members of the medical profession were elated, 'Success after many years of patient waiting', were the words of the President of the College." This feeling of success was short-lived, however, as the plan ultimately failed.



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REQUESTED PROVINCIAL "ROYAL COMMISSION" AS PART OF
CAMPAIGN

Reference:

108. The most recent plan, prior to their currently announced alternatives, was proposed in 1946 when the College of Physicians and Surgeons requested the appointing of a Royal Commission.

Comment:

109. That was one year after the opening of the Canadian Memorial Chiropractic College in Toronto and two years after the Report of the Baruch Committee on Physical Medicine in the United States. It is not considered by us to be a coincidence that this plan was attempted just after these happenings.

110. The plan itself was quite simple. The College, according to Mr. Noble's report, considered that it should "forestall" any further progress by the chiropractic profession. They attempted to accomplish this by asking the Premier of Ontario to appoint a Royal Commission to "report on all phases of medical education". The Premier is reported to have received the suggestion favourably. It was their hope that the evidence presented to this Commission would result in a finding that would enable them to oppose successfully any further progress by our profession. However, the Premier later left the provincial political scene and the Commission was never appointed.

THE NEED FOR A "CHIROPRACTIC ACT" IN ONTARIO

Reference:



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111. It seems quite apparent from the history recorded by Mr. Noble, that the representations made to this present Commission by the College of Physicians and Surgeons of Ontario, with respect to their desire to license chiropractors, constitutes their seventh or eighth plan of attack against our profession.

Comment:

112. In asking for the right to license chiropractors to-day, the College of Physicians and Surgeons is repeating a request which was denied them by the Provincial Government in 1923, and which no other province has granted. It would be more in keeping with legislation in other provinces if the Chiropractic Act, which our Board presented to the Department of Health, and which stimulated the study undertaken by the College of Physicians and Surgeons, were to be granted. This would enable our profession to function more effectively, it would help to provide funds for educational purposes, and it would enable us to maintain and further enhance standards of education and practice without feeling that someone was determined to "elevate chiropractic to its own destruction."

GENERAL COMMENTS

113. On pages 54 and 57 there are several statements which require rebuttal. We shall make but brief reference to them here.

Reference:



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114. (1) "They have done nothing to justify the rights they obtained; they have contributed nothing to scientific progress or the conquest of disease....."

Comment:

115. We would refer you to the brief which we presented to this Commission with particular reference to the Exhibit 13, Medicine and Chiropractic by Weiant:

Page 6 - Neglected Phases of Medical Education

Page 50- The Medical Plea for Manipulation

Page 91- The Medical Investigation of Chiropractic in Germany.

Canadian Chiropractic Association Appendix 1 -

Manipulation in Back Pain, from Canadian

Medical Association Journal, July 15, 1958.

Canadian Chiropractic Association Appendix 11 -

Chiropractic Theory - by Weiant

Canadian Chiropractic Association Appendix 111 -

Pain Syndromes in the Vertebral Column

and Their Amenability to Manipulative

Treatment, from the Canadian Medical

Association Journal, April 1, 1958.

Exhibit 20 - The Vertebral Column, by IIIi.

Cineroentgenography of the spinal column by IIIi

demonstrating vertebral misalignments.

This work is to be extended by the

accredited colleges of the National

Chiropractic Association including Canadian

Memorial Chiropractic College. The

"They have done nothing to justify the

(1)

114.

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nothing to do with the progress

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Comment:

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Witness:

Page 6 - Medical aspects of Medical Association

Page 50 - The Medical Association for Manipulation

Page 91 - The Medical Association of Chiro-

practic in Canada.

Canadian Chiropractic Association Appendix I -

Manipulation as a part of Chiropractic, from Canadian

Medical Association Journal, July 15, 1952.

Canadian Chiropractic Association Appendix II -

Chiropractic Theory - by Weisheit

from testimony in the Vertebral Column

and their responsibility to Manipulative

Treatment, from the Canadian Medical

Association Journal, April 1, 1952.

Exhibit 20 - The Vertebral Column, by Hill.

Chiropractic aspects of the spinal column by Hill

demonstrating vertebral malalignments.

This work is to be extended by the

Chiropractic Association including Canadian

Medical Chiropractic College. The



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research equipment is being installed in the Lincoln Chiropractic College in Indianapolis for use by other colleges as required.

Reference:

116. (2) "Their theories of disease have no scientific basis".

Comment:

117. If this is really considered to be true, why does the College of Physicians and Surgeons wish to license chiropractors? Why has the Canadian Medical Association Journal reported improvements in diagnosis and treatment through chiropractic procedures? We refer you to that section of our brief entitled "Medicine and Chiropractic" and also to the same exhibits as those listed under (1) above, plus Exhibits 11, 12, 14, 16, 17, 19.

Reference:

118. (3) "The treatments they provide can be given just as effectively by methods practised by physiotherapists."

Comment:

119. Mr. Noble has admitted that the standards of education training demanded of chiropractors are higher than those required of physiotherapists. He has also stated, "...the chiropractors have succeeded in completely overshadowing the physiotherapists in public acceptance.....". These facts would certainly seem to indicate that there is a difference in the two methods of treatment. By means of these



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different methods, both groups are providing a valuable and needed service, and neither is prepared to offer the services provided by the other.

Reference:

120. (4) "All chiropractors are really doing is hoodwinking the public; they have no proper training to warrant their diagnosing the symptoms of their patients."

Comment:

121 If we have succeeded in hoodwinking any one, we have succeeded in hoodwinking 87% of the legislative bodies in North America, an enviable feat. Would Mr. Noble have us believe that 87% of the law-making bodies are all wrong?

122. As for diagnosis we refer you to the writings of Mennell (both Jr. and Sr.) Canadian Chiropractic Association Exhibits 11 and 12; Goldthwait, Canadian Chiropractic Association Exhibit 16; Weiant, Canadian Chiropractic Association Exhibit 13; Parsons, Canadian Chiropractic Association Appendix 1; Canadian Medical Association Journal, Canadian Chiropractic Association Appendix 111, all of which say in one way or another that medical practitioners have made errors in diagnosis because they did not understand the role of the spine and referred pain. They also state, as found in the Canadian Chiropractic Association Appendix 111 and others, that chiropractic methods have brought about improvements in the diagnosis and treatment of many painful conditions. What greater contribution can be made in the field of health than

different methods, both groups are providing a valuable and needed service, and neither is prepared to offer the services provided by the other.

(4) "All chiropractors are really doing is

hoodwinking the public; they have no

proper training to warrant their diagnosis

the symptoms of their patients."

Comment:

If we have succeeded in hoodwinking any-

one, we have succeeded in hoodwinking 8% of the legis-

lative bodies in North America, an amazing feat.

Would Mr. Noble have us believe that 8% of the law-

making bodies are all wrong?

As the Senators we refer you to the

writings of McNeill (both Mr. and Dr.) Canadian

Chiropractic Association, January 19, and Dr. Goldsworthy

Canadian Chiropractic Association, Exhibit 10; Warrant,

Canadian Chiropractic Association, Exhibit 11; Parsons,

Canadian Chiropractic Association, Exhibit 12; Canadian

Medical Association, Journal, Canadian Chiropractic

Association, Appendix 11, all of which say in one

way or another that medical practitioners have made

errors in diagnosis because they did not understand

the role of the spine and related areas. They also

state, as found in the Canadian Chiropractic Association

Appendix 11 and others, that chiropractic methods

have brought about improvements in the diagnosis and

treatment of many kinds of conditions. What greater

contribution can be made in the field of health than



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improvements in diagnosis and treatment?

123. The extent of these improvements is, of course, dependent to a large degree on the amount of money available to the profession for research purposes. We have not received one cent in government aid, either for research or education and we feel under these circumstances that the record we have established is an enviable one.

124. Concerning training in diagnosis we refer you to the calendar of the Canadian Memorial Chiropractic College and the examinations conducted by the Board of Directors of Chiropractic of Ontario, listed in the Ontario section of our original brief.

ROENTGENOLOGY

Reference:

125. The reference on page 57 to which we take exception is in regard to the use of x-ray equipment by chiropractors. After recommending that the use of x-ray machines by chiropractors should not be permitted, he proceeds to show his lack of knowledge of this subject by taking issue with terminology used in some of our provincial legislation in which chiropractors are authorized to use x-ray equipment for the purpose of taking "shadow photographs". The author apparently feels that this term refers to some peculiar development by the chiropractic profession that is different from the use of x-ray machines within the medical profession.



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He states, "If there are machines available that can take only this form of photograph, and such photographs are a desirable adjunct to chiropractic methods of treatment, the right limited to shadow photographs might be conceded, etc.....".

Comment:

126. What Mr. Noble fails to understand is that diagnostic or postural x-ray films are in fact shadow photographs. Webster's dictionary defines "shadowgraphs" as "a shadow photograph or image made by x-rays passing through an object and falling on a sensitized film". Text books on the subject make the same reference.

127. The Canadian Medical Association Journal of April 1, 1958, Canadian Chiropractic Association (Appendix 111) reports on the beneficial results of chiropractic therapy in a forceful manner and the article contains this statement; "After repeated warning that no type of manipulation should be carried out without x-ray examination, the author describes the 'chiropractic' manoeuvres he uses...." If medical investigators recognize the need for x-ray examination prior to manipulation, as a safety factor, one is tempted to ask why they wish to have the chiropractors manipulating without the right to use this safety device? We refer you to our brief for the training of a chiropractor in the use of x-ray equipment.

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He states, "If there are machines available that can take only this form of photograph, and such photographs are a desirable adjunct to chiropractic methods of treatment, the right limited to shadow photographs might be conceded, etc., etc."

Comment:

126. What Mr. Noble fails to understand is that diagnostic or postural x-ray films are in fact shadow photographs. Webster's dictionary defines "shadowgraph" as "a shadow photograph or image made by x-rays passing through an object and falling on a sensitized film". Text books on the subject make the same reference.

127. The Canadian Medical Association Journal of April 1, 1938, Canadian Chiropractic Association (Appendix III) reports on the beneficial results of chiropractic therapy in a careful manner and the article contains this statement: "After repeated warning that no type of manipulation should be carried out without x-ray examination, the author described the 'chiropractic' maneuvers he used." If medical investigators recognize the need for x-ray examination prior to manipulation, as a safety factor, one is tempted to ask why they wish to have the chiropractors manipulating without the right to use this safety device? We refer you to our brief for the training of a chiropractor in the use of x-ray equipment.

Reference:



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THE TITLE DOCTOR

128. On page 8, paragraph 1, it is stated that physicians now have "the exclusive right to use the title 'doctor' ". This refers to a section in The Medical Act which states that the title 'doctor' may not be used by anyone as an occupational designation in the treatment of human ailments unless he is registered under the Medical Act. An exception is made for dentists.

Comment:

129. It is well known that the title "doctor" is not an "occupational designation" but rather a degree signifying a certain level of academic attainment in many varied fields. The doctorate degree has never been the exclusive property of any professional group and since the restrictive clause in Ontario's Medical Act according to Mr. Noble, was inserted for the specific purpose of denying the use of this title to chiropractors and osteopaths, (see page 8, Noble report) we hereby recommend that medicine's "exclusive right to use the title 'doctor'" be revoked. Since this is a matter within the jurisdiction of the province, we would request that this Commission recommend to the Federal Government that the Provincial Government be requested to take the necessary action.

COLLEGE OF PHYSICIANS AND SURGEONS EXCEEDS ITS
AUTHORITY

Reference:



126.

On page 8, paragraph 1, it is stated that physicians now have "the exclusive right to use the title 'doctor'". This refers to a section in The Medical Act which states that the title "doctor" may not be used by anyone as an occupational designation in the treatment of human ailments unless he is registered under the Medical Act. An exception is made for dentists.

127.

It is well known that the title "doctor" is not an "occupational designation" but rather a degree signifying a certain level of academic attainment. It has been the custom of the professional group and since the restrictive clause in the Medical Act according to the title, was inserted for the specific purpose of denying the use of this title to chiropractors and osteopaths, (see page 8, Note 1) we hereby recommend that medicine's "exclusive right to use the title 'doctor'" be revoked. Since this is a matter within the jurisdiction of the professional group, we would request that this Commission recommend to the Federal Government that the Privileges Committee be requested to take the necessary action.

OFFICE OF PHYSICIANS AND SURGEONS EXCEPT ITS
QUALITY



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130. On page 28, paragraph 1, Mr. Noble discusses the alternatives for overpowering the osteopathic profession in Ontario. After stating that osteopathy is in fact the practice of medicine, we find this interesting comment:

131. "It would be incongruous and dangerous to the public that different groups engaged in the practice of medicine be evaluated as to professional training and accredited for license by different agencies irrespective of how competent and conscientious these might be."

132. This view makes it clear that the concern is not for high standards in the public interest, but for the development and control of a monopoly. The author of the report recognizes the danger inherent in this activity for he states under the heading of "Disadvantages", as follows:

- 133.
1. It has already failed in the case of the Drugless Practitioners Act.
 2. It is open to popular but uninformed interpretation as inspired by improper motives such as bigotry or the desire to maintain a closed profession. (With that statement we have no argument.)
 3. Legislatures are inclined to ignore principle when contentious legislation is dealt with.
 4. Failure to reach a solution could

14754 Morgan

130.

On page 14, paragraph 1, Mr. Noble discusses the alternatives for overcoming the osteopathic profession in Ontario. After stating that osteopathy is in fact the practice of medicine, we find this interesting comment.

131.

"It would be incongruous and dangerous to this, that different groups engaged in the practice of medicine be evaluated as to professional training and accredited for licensure by different agencies. It is necessary to have uniformity and consistency in these matters."

132.

This view takes it clear that the concern is not for high standards in the public interest, but for the development and control of a monopoly. The author of the report recognized the latter interest in this activity for he said under the heading of "Recommendations", as follows:

133.

"It has already been noted in the case of the Drugless Practitioners Act, that it is open to, popular and uniform. The organization as indicated by the proper bodies such as dignity or respect to maintain a closed profession. (With what statement we have no objection.)

3.

Legislatures are inclined to ignore principle when conventional legislation is difficult with. It is to reach a solution could



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result in the function of the College being taken over by a Department of Government as is the case throughout the United States."

134. Here the author appears to recognize that if the College oversteps its authority by interfering in the affairs of other professions, it may have to turn over its functions to a Department of Government. We submit that the College of Physicians and Surgeons of Ontario has in fact been exceeding its authority in this respect for over 50 years and that this is adequately recorded in the over 100 pages of the Noble Report.

135. Such activities on the part of the College have seriously curtailed the proper and legitimate development of the chiropractic profession in this province and we therefore recommend that this Commission make recommendations which will bring an end to this irresponsible and selfish interference in the affairs of our profession, and which will also provide us with the degree of autonomy and control that has been consistently denied us.

136. Our profession is deserving of the opportunity to function under the proper type of professional legislation such as has been recommended by the Board of Directors of Chiropractic of Ontario, and the Ontario Chiropractic Association, to the Government of this Province, without unjust interference that succeeds only in expending our resources in needless conflict.



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Government. We submit that the College of Physicians
and Surgeons of Ontario has in fact been exceeding its
authority in this respect for over 20 years and that
this is adequately recorded in the over 100 pages
of the Noble Report.

Such activities on the part of the
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and the Ontario Chiropractic Association, to the
Government of this Province, without unjust inter-
ference that succeeds only in expending our resources
in needless conflict.



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CONCLUSION

137. On page 53 Mr. Noble states that there may be a division within the ranks of the chiropractors in this Province. He then goes on to say that: "such a development would be very helpful, but is not to be counted on." Helpful to the College of Physicians and Surgeons, we presume, and most emphatically it is not to be counted on!

138. The Canadian chiropractic profession is united from coast to coast as our presentations to this Commission have testified, and we would advise the College of Physicians and Surgeons of Ontario that reports such as the one they have presented to this Commission will do more to further strengthen the bonds of unity within our profession than any other single factor.

139. The true conclusion to this rebuttal cannot be written at this time. It must await the concerted action of all levels of government aimed at eliminating the monopolistic tendencies on the part of one member of the healing arts professions and its adverse influence upon the affairs of other professions, in the interests of the public.

140. In our original submission we have pledged that we are prepared to co-operate with all other professions in the healing arts in any program designed to improve the health services available to the people of Canada. We will keep that promise to the best of our ability under these difficult cir-



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cumstances, and we ask one final question - Will
the medical profession and its organizations make
the same promise?

Respectfully submitted.



...and we are in a position to ...
the medical profession and its organizations make
the same practice?

...

...

...



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APPENDIX 1

(Referred to on page 12720)

The American Medical Association has stated that "limited practice acts are almost impossible to enforce satisfactorily".

We present in this Appendix quotations from many representatives of State governments, indicating that the chiropractic legislation in their jurisdiction is operating effectively and has been found satisfactory.

These quotations are from the publication: "The Case For Chiropractic Regulatory Legislation", published by the National Chiropractic Association.

ARIZONA

Nov. 16, 1927.

"We have had a Board of Chiropractic Examiners since 1921, and so far as I have been able to learn, they have co-operated in every way with our health departments, and we have no reason to regret having established such a Board."

(Signed) Geo. W. P. Hunt, Governor.

Nov. 23, 1959.

"It is the general feeling that the Arizona chiropractic statute does serve a very useful service by providing the people of Arizona a necessary



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(Referred to on page 12750)

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stated that "limited practice acts are almost impossible to enforce satisfactorily".

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APPENDIX

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established such a Board."

(Signed) Geo. W. P. Hunt, Governor.

"It is the general feeling that the

Arizona chiropractic statute does serve a very useful

service by providing the people of Arizona a necessary



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health service.

"I signed this legislation on March 24, 1959. It was felt by all segments of the chiropractic profession that this legislation would be helpful in that it raised educational standards and improved public protective measures, which had been in force without an amendment since 1921."

(Signed) Paul Fannin,
Governor of Arizona.

Nov. 17, 1959.

"This is in response to your communication dated November 11, 1959, relating to the Arizona Chiropractic Law. Specifically, you inquire if chiropractic regulatory statutes afforded a sound means of regulating the practitioners of this health service and at the same time provided adequate protection to those members of the public availing themselves of it.

"We think that the Arizona Chiropractic Act is effective. To date, we have not been troubled in the enforcement of the act. The law adequately prevents fraudulent, incompetent, practitioners. The act effectively controls and regulates those who are licensed to practice in this state. We think the Arizona public is safe under our present act."

(Signed) H. B. Daniels,
Asst. Attorney-General
State of Arizona

CALIFORNIA

July 29, 1926.

"Chiropractic as a profession, most

Health services.

"I signed this legislation on March 24,

1959. It was felt by all segments of the chiropractic

profession that this legislation would be helpful in

that it raised educational standards and improved public

protective measures, which had been in force without an

amendment since 1921."

Governor of Arizona

Nov. 14, 1959.

"This is in response to your communication

dated November 11, 1959, relating to the Arizona Chiro-

practic Law. Specifically, you mention the chiropractic

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in the enforcement of the act. The law absolutely pre-

vents fraudulent, incompetent, and irresponsible

effectively controls and regulates those who are licensed

to practice in this state. We think the Arizona public

is safe under our present act."

(Signed) H. H. Miller,
Attorney General
State of Arizona

"Chiropractic as a profession, most



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certainly has raised in standard, and, as a natural consequence, chiropractors as practitioners have advanced in the same ratio.

"We can state with positive assurance, that the chiropractic law has met with the approval of the people.

(Signed) James Compton, Secretary,
State Board of Chiropractic
Examiners

DELAWARE

1937

"Without going into the merits of this profession, its practice has been in effect so long that the public has recognized it and many people believe in it and have assured me that they or some of their families have been benefited by this treatment.

"Both bodies of the Legislature believed that the profession should be recognized and the public safeguarded from inefficient and improperly trained practitioners Members of the General Assembly personally solicited me to sign this bill, having received treatment from various members of the profession.

"We should all realize that chiropractors are with us to continue their profession indefinitely, therefore, believing it the best thing to do, I approved the bill which calls for a Board of Examiners."

(Signed) Richard C. McMullen,
Governor

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DELAWARE

May 30, 1943.

"Our law has been operating very successfully for nearly eight years. It guarantees a high standard practitioner for the State and protection to the public. The medical and other healing professions of this State are as pleased with the law as we are."

(Signed) J. Harold Mowen,
Secretary-Treasurer,
State Board of Chiropractic Examiners.

Nov. 13, 1959

"Receipt is acknowledged of your letter of November 11, 1959, asking our views concerning the adequacy of existing chiropractic regulatory statutes. We have been in office since January 1, 1959, and have had no complaints. I have served as a Deputy Attorney General previously and there were no complaints during that period.

(Signed) Januar D. Bove, Jr.,
Attorney-General State
of Delaware.

Nov. 16, 1959.

"The Chiropractic Practice Act has been a great help in the regulation of chiropractic in Delaware. It was passed in 1937. Since that time only well qualified doctors of chiropractic can practice in Delaware. It is in the interest of public health and welfare that all states have a licensing law regulating the practice of chiropractic".

(Signed) W. F. Cook, D.C.,
Secretary,
State Board of Chiropractic Examiners.

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HAWAII

Dec. 2, 1959.

"It is our opinion that the Hawaii Chiropractic Act is sound law. This law has been in our books since 1925. This office has had no occasion to prosecute any person for violation of this law since said date.

"Therefore, it is our opinion that the Hawaii Chiropractic Act provides adequate protection to the public."

(Signed) Peter A. Aduja,
Deputy Attorney General.

IDAHO

July 31, 1926

"The Idaho Chiropractic Law has been very beneficial and has placed the profession on a higher standard, thus preventing incompetent practitioners from operating in this State.

(Signed) F. A. Jeter,
Commissioner of Law Enforcement.

Nov. 16, 1959.

"In the course of about five years of administration in this office, it has been our experience that the laws of the State of Idaho are adequate insofar as chiropractic regulatory legislation is concerned. It is true, of course, that from time to time these laws must be in some way modernized and changed to conform



Dec. 2, 1939.

"It is our opinion that the Hawaii

Chiropractic Act is sound law. There has been in our
house since 1925. This office has had no occasion to
process any person for violation of this law since
said date.

Therefore, it is our opinion that the
Hawaii Chiropractic Act provides adequate protection to
the public."

(Signed) Walter A. ...
...

WALTER A. ...

Dec. 31, 1939

"The same Chiropractic law has been very
beneficial and has placed the profession on a higher
standard, thus preventing incompetent practitioners from
operating in this State.

(Signed) W. A. ...
Commissioner of Law Enforcement

"In the course of the five years of

administration in this office, it has been our experience
that the laws of the State of Hawaii are adequate insofar
as chiropractic regulatory legislation is concerned. It
is true, of course, that from time to time there may
must be in some way modified and changed to conform



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with changing patterns and I think perhaps this has been attended to by the Idaho Chiropractic Association. Therefore, this office would not at this time have any recommendations to be considered by the profession."

(Signed) Robert E. Hodge,
Assistant to the Governor.

Nov. 19, 1959

"It is my opinion that our statutes governing chiropractic practice reasonably well safeguard the public health. Our statutes governing this field of practice in the healing art were originally enacted in 1919 and there appears to have been very little litigation, if any, bearing on its effect on the public health, which indicates that practice under the statutes has shown no danger to public health.

(Signed) E. G. Elliott,
Asst. Attorney-General,
State of Idaho.

MISSOURI

Nov. 16, 1959.

"My office has never been called upon to render an opinion on whether or not the chiropractic law as it exists safeguards the public health and welfare of the State of Missouri.

"To the best of my knowledge, there has never been any official charge made by the State Chiropractic Board of Examiners or the Department of Health and Welfare that said law was ineffective. Therefore, it would appear that the present chiropractic law does



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regulate their members fairly effectively.

(Signed) John M. Dalton,
Attorney-General,
State of Missouri.

Dec. 7, 1959.

"I wish to acknowledge receipt of your correspondence of November 12, 1959, asking that an appraisal be made of licensing laws and their effect on chiropractic in Missouri.

"Missouri has operated for some years under a very satisfactory chiropractic law. All appearances indicate that legislation governing chiropractic in Missouri has served a useful purpose by providing necessary health service. At this time I cannot suggest changes to our organic law governing chiropractic."

(Signed) James T. Blair, Jr.,
Governor.

MONTANA

June 11, 1943.

"I am very glad to advise you that our chiropractic laws have worked satisfactorily. The chiropractors generally co-operate with the health authorities in the maintenance of sanitary safeguards."

(Signed) Sam C. Ford,
Governor.

Nov. 25, 1959

"This is in reply to your inquiry of November 11 regarding the effectiveness of Montana's Chiropractic Act.

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regulate their members fairly effectively.

(Signed) J. M. Fenton,
Veterinarian,
State of Missouri.

Dec. 1, 1933.

"I wish to acknowledge receipt of your

correspondence of November 12, 1933, noting that an
appraisal be made of licensing laws and their effect on
chiropractic in Missouri.

"Missouri has operated for some years

under a very satisfactory chiropractic law. All

practicing in Missouri have served a usual program by
providing necessary health service. At this time I
cannot suggest changes to our organic law governing

chiropractic."

(Signed) James I. Blair, Jr.,

"I am very glad to receive your letter
concerning the laws we worked satisfactorily. The chiro-
practics generally co-operate with the health authorities
in the maintenance of sanitary safeguards.

Nov. 25, 1933

"This is in reply to your letter of

November 11 regarding the effectiveness of Montana's



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"As far as my office is concerned no complaints have been received that the present law is inadequate."

(Signed) Forrest H. Anderson,
Attorney General.

PENNSYLVANIA

Sept. 23, 1959.

"Prior to the time when chiropractors became licensed in 1951, there was an ever-increasing demand on the Commonwealth by the profession and the public to give chiropractic its proper place in the healing arts. Certain qualifications, standards and limitations were decided upon which resulted in The Chiropractic Registration Act of 1951.

"At the present time all of the doctors of chiropractic are licensed and enjoying the benefits of licensure. Their number is ever-increasing in the state as is evidenced by the amount of new applicants taking the state boards each year. The conjecture would indicate that there is a greater demand for chiropractors. Consequently, the people of this state must be enjoying the benefits derived from this great healing profession.

"I must say that the chiropractic profession is endeavouring to keep a surveillance on its profession by symposiums and compulsory attendance at educational conferences to raise its standards and to keep abreast of modern advances in the profession."

(Signed) Charles H. Boehm,
Superintendent,
Department of Public Instruction.



"As far as my office is concerned no
complaints have been received that the present law is
inadequate."

Sept. 12, 1935

"Prior to the time when chiropractors
became licensed in 1927, there was an ever-increasing
demand on the Government for the profession and
the public to give chiropractors the proper place in the
medical profession. The Government, however, was
hesitant to do so until the public decided upon which resulted in the

"At the present time all of the doctors
of chiropractic are licensed and enjoying the benefits
of their work. Their number is ever-increasing in the
state as is evidenced by the amount of new applications
being the state board each year. The committee would
indicate that there is a greater demand for chiropractors.
Consequently, the people of this state must be enjoying
the benefits derived from this great healing profession.
"I must say that the chiropractic pro-

tection is endeavoring to keep a surveillance on its
profession by symposiums and conferences, attendance at
educational conferences to raise its standards and to keep
abreast of modern advances in the profession."

(Signed) Charles H. Brown,

Department of Public Instruction



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VERMONT

May 15, 1943.

"So far as my knowledge goes, the operation of the law regarding registration of chiropractors has been satisfactory and I believe it might be well taken as an example of a good state law."

(Signed) William H. Wills,
Governor.

Nov. 30, 1959.

"Most legislative endeavours are in some way or other for the protection of the public health and welfare. The enactment of fair chiropractic legislation and a creation of a Chiropractic Examining Board is Definitely a step in this direction.

"The Vermont State Chiropractic Act was created and passed by both houses in 1919, forty years ago, and still stands intact from its origin with improvements added from time to time. At no time since this act has it caused a problem. The fact is that the public have had the protection of a qualified chiropractic health service surpassed by none. The Board in co-operation with the state association has, from time to time, elevated the standards and qualifications of the profession in the State of Vermont, in step with progress.

"We, in Vermont, firmly believe that a state without fair and equitable legislation governing chiropractic is exposing the public in that state to unregulated and chaotic conditions. Fair and equitable chiropractic regulation has eliminated the unqualified



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has been as in knowledge, the

operation of the industry, a regulation of which has been satisfactory and a policy it might be well taken as an example of a good state policy.

Nov. 20, 1930.

These legislative enactments are in some way or other for the protection of the public health and welfare. The enactment of this bill, which is legislation and a creation of a Therapeutic Licensing Board is definitely a step in this direction.

The former State Pharmaceutical Act was

created and passed by both houses in 1917, forty years ago, and still stands intact from its origin with improvements added from time to time. We no longer since this act has not caused a problem. The act is that the public has had the protection of a regulated and controlled health service supervised by the Board in legislation with the state seal, and the time is now.

elaborated the standards and qualifications of the profession in the State of Vermont, it goes with progress. The, in Vermont, firmly believe that a

state without fair and scientific legislation governing chiropractic is exposing the public in that state to unregulated and chaotic conditions. Fair and scientific chiropractic regulation has eliminated the unregulated



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chiropractor and is certainly in the interest of public health and welfare.

(Signed) Joseph S. Hoyt, D.C.,
President
Vermont Board of Chiropractic
Examination and Registration.

WYOMING

Dec. 2, 1959

"The Wyoming Chiropractic Act initiated in 1929 has been most easily administered. At no time during the 30-year period has the law been in question in the courts. Neither has there been a case that required court action to regulate or control any licensed chiropractor and the problem of unlicensed persons has not been difficult for the board to handle.

"The fact that the State Board of Chiropractic Examiners has not been hampered by conflicting regulations of a Basic Science Board, has also aided the administration of the law. Full co-operation of the State Medical Officer and the State Board of Health, is much in evidence. Standards for those wishing licenses in the state have been advanced in 1931, 1939 and 1957, and have given the people of Wyoming a higher type of chiropractic health service.

(Signed) G.L. Holman, D.C.,
Secretary-Treasurer,
State Board of Chiropractic
Examiners.

TERRITORY OF HAWAII

June 17, 1943

"The Territory of Hawaii has been fortunate



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in having a sound chiropractic law which has been modified from time to time as changing conditions warranted revision. The Board of Chiropractic Examiners has endeavored to maintain high standards among practicing chiropractors.

"As far as the Board of Health is concerned, the operation of the chiropractic law in the Territory has been satisfactory. The chiropractic profession has co-operated well with the health authorities."

(Signed) Richard K. C. Lee, M.D.,
Director of Public Health,
Board of Health.



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in having a sound chiropractic law which has been
modified from time to time as changing conditions warranted.
The Board of Chiropractic Examiners has en-
deavored to maintain high standards among practicing
chiropractors.

"As far as the Board of Health is con-
cerned, the creation of the chiropractic law is in the
territory has been satisfactory. The chiropractic pro-
fession has cooperated well with the health authorities."

Director of Public Health,
State of Oregon



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APPENDIX 11

(Referred to on page 12739)

A partial list of cases in which chiropractors have appeared in court as expert witnesses.

Supreme Court of Ontario, St. Catharines, - May 19 - 21, 1952 - Rovers et al vs Valvasori.

Supreme Court of Ontario, Toronto - May 13, 1959 - Arnott vs Unsatisfied Judgment Fund.

Supreme Court of Ontario, Toronto - September 6, 1955 - Kitay vs Fairgrieve and W. F. Whittey

Surrogate Court, Sarnia - November, 1953 - Scott vs. Scott

Supreme Court of Ontario, Peterborough, - April 1962 - McWilliams vs. Insurance Company (to be identified)

Supreme Court of Ontario, Toronto - 1961 - E. Clark vs. Great-West Life Assurance Co.

Supreme Court of Ontario, St. Catharines - Spring 1955 - Watson vs. Bird.

County-Court, Goderich - October 1960 - Taylor vs. Lovett.

Muskoka District Court, Bracebridge - June 14, 1961 - Terelly vs. Clayton.

District Court, Sault Ste. Marie - June 12, 1959 - H. Pratt and R. Pratt vs. G. E. Marshall.

District Court, Sudbury - February 8, 1962 - R. Schwartz vs. A. Gagnon (Nickel City Parking).

The Workmen's Compensation Board of Ontario, Sudbury - Summons chiropractor to witness in the matter of claim 4952244.



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APPENDIX A

(Referred to on page 12750)

- A partial list of cases in which witness-
prosecutors have appeared in court as expert witnesses.
- Supreme Court of Ontario, 2d Division, - May 19 - 21, 1951 - Powers et al. vs. Vancouver.
- Supreme Court of Ontario, 2d Division, - May 13, 1951 -
Attorney vs. Unsettled Judgment Fund.
- Supreme Court of Ontario, 2d Division, - September 6, 1951 -
Kitty vs. Higgins and W. F. Witley.
- Supreme Court, Ontario - November, 1951 -
- Supreme Court of Ontario, Peterborough, - April 1952 -
McWilliams vs. Insurance Company (to be identified)
- Supreme Court of Ontario, Toronto - 1951 -
- Supreme Court of Ontario, St. Catharines - Spring 1952 -
Ranson vs. Hurd.
- County Court, Goderich - October 1950 -
Taylor vs. Lovett.
- Ontario District Court, Exeter - June 14, 1951 -
Terrell vs. Clayton.
- District Court, Smith's Bay, Nfld. - June 12, 1951 -
R. Pratt and R. Pratt vs. C. H. Marshall.
- District Court, Pelly - February 8, 1952 -
R. Schwartz vs. A. Gagnon (Niche City Parking).
- The Women's Compensation Board of Ontario, Sudbury -
Commons Director as witness in the matter of
claim 495224.



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Supreme Court of British Columbia - Judgment March 27, 1961 -

Elsie Goss vs. Gessaroli

Supreme Court of British Columbia, Victoria B.C. -

Decision November 25, 1960, Maxwell vs. Doney

Exchequer Court of British Columbia - Vancouver -

Mrs. T. McDonald vs. Messrs. Griffiths &

McLellan were Counsel for the plaintiff.

Supreme Court of British Columbia, - May 15, 1962 -

D. Walker vs. G. Lenein and Dueck on Broadway.

Supreme Court of British Columbia - Decision March 8, 1956 -

A. Fulin vs. Morrison.

Supreme Court of British Columbia - September 7, 1959 -

E.G. Johnston vs. S.M. Curey and Alpine

Insurance Company Ltd.

Supreme Court of British Columbia - 1958 -

Carlisle Kersley.

Supreme Court of British Columbia, Nanaimo - October 29 -

1946 - McKnight vs. J. R. Yates.

Supreme Court of British Columbia - June 1954 -

Shelderate vs. Grenard.

Supreme Court of British Columbia - 1957 -

M. Clark vs. K. Hetherington

Supreme Court of Alberta, Calgary - May 22, 1947 -

Olive Nadeau vs. Bell Taxi Company.

Supreme Court of Alberta, Edmonton - November 4, 1959 -

Wm. T. Roper vs. J. Mazurek.

Supreme Court of Alberta, Lethbridge - March 23, 1961 -

A. Clark vs. R. Fitzner and A. Fitzner.

Supreme Court of Alberta, Lethbridge - April 17, 1962 -

P. Regal vs. A. Toren and G. Toren.



1977

Supreme Court of British Columbia - 1977 March 27, 1977
 Hsieh Goss vs. Goss
 Supreme Court of British Columbia, Victoria B.C. -
 Decision November 22, 1966, 1966, 1966, 1966
 Rehearing Court of British Columbia - Vancouver
 Motion was denied for the plaintiff
 Supreme Court of British Columbia - May 15, 1977 -
 H. Walker vs. G. Jones and Queen of Broomfield
 Supreme Court of British Columbia - Decision March 8, 1977
 A. Smith vs. Morrison
 Supreme Court of British Columbia - September 7, 1977
 H.C. Johnston vs. S.M. Carey and Alpine
 Insurance Company Ltd.
 Supreme Court of British Columbia - 1977 -
 Supreme Court of British Columbia, Victoria - October 20 -
 1977 - H.C. Johnston vs. J. P. Yates
 Supreme Court of British Columbia - June 1977 -
 H.C. Johnston vs. Goss
 H. Clark vs. J. Hetherington
 Supreme Court of Alberta, Calgary - May 2, 1977 -
 Olive Hedges vs. Bell Text Company
 Supreme Court of Alberta, Edmonton - March 23, 1977
 A. Clark vs. J. Hetherington and A. Hetherington
 Supreme Court of Alberta, Edmonton - April 1, 1977 -
 H.C. Johnston vs. A. Hetherington and J. Hetherington



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SECTION 111

SUBMISSION TO THE
ROYAL COMMISSION ON HEALTH SERVICES

BY

THE CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

PRESENTED BY

D. W. MACMILLAN, D.C.,
CHAIRMAN, BRIEF COMMITTEE,
CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

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SECTION III

SUBMISSION TO THE

BY

PRESENTED BY

PAPER NO.

TITLE

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Mr. Chairman and members of the Commission:

INTRODUCTION

1. The Canadian Memorial Chiropractic College wishes to associate itself with the presentations made by the Canadian Chiropractic Association and the Ontario Chiropractic Association in refuting information submitted to this Commission through a report prepared for the College of Physicians and Surgeons of Ontario, by its solicitor, Mr. W. H. Noble, Q.C. The report is entitled, "A Study of Osteopathy and Chiropractic."
2. Because of the inaccurate statements made with respect to chiropractic education in the Noble report, and because of specific references to our Canadian college, we find it necessary to refute certain of these statements and to clarify others. We now refer to that report.

CAUSES OF DISEASE

Reference:

3. On page 35 the author states, as a conclusion reached by a Dr. Boyd of Louisiana, that the chiropractic theory holds that all diseases and illnesses are due to one cause, namely, a slight dislocation or subluxation of one or more of the spinal vertebrae.

Comment:

4. The presentation by the Ontario Division



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Mr. Chairman and members of the Commission:

THE CANADIAN MEMORIAL CHIROPRACTIC

The Canadian Memorial Chiropractic College wishes to associate itself with the presentations made by the Canadian Chiropractic Association and the Ontario Chiropractic Association in refuting information submitted to this Commission through a report prepared for the College of Physicians and Surgeons of Ontario, by its solicitor, Mr. W. H. Noble, Q.C. The report is entitled, "A Study of Osteopathy and Chiropractic."

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Comment:

The presentation by the Ontario Division



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Division of the Canadian Chiropractic Association has effectively refuted this statement and indeed it was clearly said in our original submission to this Commission that we did not make any such claim. We wish at this time to make it very clear that the course of study at the Canadian Memorial Chiropractic College teaches the student that there are many underlying causes of disease affecting the human body, and detailed attention is given to such factors as lowered tissue resistance, overwhelming exposure of the body to bacterial agents, malnutrition, chemical irritants, etc.

OUTDATED QUOTATION

Reference:

5. On page 36, paragraph 2, line 12 to 15, the Noble report quotes a Professor R. R. Bensley, of the University of Chicago who states: "In a period of twenty-nine years during which time I have been Director of this Department we have never found in our dissecting rooms a single instance in which the foramina or aperture between the vertebrae, through which the nerve branches issue from the spinal cord, have been so narrowed as to cause pressure upon nerves."

Comment:

6. This statement was made 28 years ago and ranks with a similar statement made by Dr. Morris Fishbein 30 years ago. Such out-dated viewpoints were thoroughly refuted in our original brief to this Commission by quoting more up-to-date authorities



12778 Morgan

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Medical Evidence

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both in the field of chiropractic and medicine. We refer you to the section entitled "Medicine and Chiropractic" in the brief of the Canadian Chiropractic Association, where, in addition to recent authoritative statements, we have also demonstrated pictorially that medicine is endeavouring to imitate the techniques of the chiropractor. Under these circumstances it is evidence of obvious bias to see in the Noble report, a statement that is 28 years old, with no reference to the changes that have taken place in medical viewpoints since that time.

7. It is appropriate to add at this time, as supplemental evidence, that experiments were conducted by the Dresden Hygienic Museum (Germany) in 1934, at the request of the Palmer School of Chiropractic, to determine whether human specimens quick-frozen after death, would reveal the same physical relationship between the nerve tissue and the bones of the spine as was found in cadavers that had been stored for long periods of time. The results of these experiments, which could not have been conducted in the United States due to legal technicalities, were recorded photographically and are available in the Osteological Museum of the Palmer College of Chiropractic. The photographs prove that the amount of shrinkage in the nerve tissue after death is so great that any attempt to prove or disprove the possibility of nerve pressure in a cadaver is almost impossible. On the other hand, the quick-frozen specimens prevented such shrinkage and demonstrated



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that the nerve tissue occupied a sufficient amount of space in its relationship to the spine, that mechanical faults in the spine could indeed produce a pressure on the nerves.

DIAGNOSIS

Reference:

8. On page 41, paragraph 2, line 5, the author states that chiropractic is a system that denies the need of diagnosis.

Comment:

9. This statement is not true. The Canadian Memorial Chiropractic College provides, during the four year course, 864 hours of study in the subject of diagnosis, which is approximately 22% of the entire course of 4500 hours. In addition to this time, the student, as a clinic interne, devotes a considerable portion of his 1,000 clinic hours to the study and application of the subject of diagnosis. Since a chiropractor accepts patients directly, he must be capable of determining when a patient should be referred to a practitioner in another branch of the healing art. The courts of Ontario have upheld this view by determining that a chiropractor is obliged to make a diagnosis of his patient's condition. We refer to the rulings of The Honourable Mr. Justice Gale, in the case, Morrow versus McGillivray, heard in the Supreme Court of Ontario, June 28, 1957.



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a pressure on the nerves.

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8. On page 41, paragraph 2, line 2, the
author states that chiropractic is a system that
denies the need of diagnosis.

Comment:

9. This statement is not true. The
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32% of the entire course of 4500 hours. In addition
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Ontario, June 28, 1957.



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ANATOMY (Human Dissection).

Reference:

10. On page 44 and 46 the author is critical of references in the college calendar to dissection as a part of the course in anatomy taught to students in our Canadian College. He states that; "the question of whether the course includes human dissection is left delightfully vague."

Comment.

11. It happens, however, that the section to which he referred is headed, "Dissection (Human). A second section is headed, "Dissection (Small Mammal)". Under the former heading, which appears following a description of all the other sections of anatomy, one reads as follows: "The student is well prepared now to appreciate fully the comprehensive knowledge to be gained by careful dissection of nerves, muscles, blood vessels and viscera. Emphasis is placed on the nervous system." Now we grant that this is not a complete description of the course in human dissection, nor is it intended to be, but it does appear under the appropriate heading so that there is no reason for confusion over whether human dissection is actually taught. The author could have verified that this course takes place by visiting one of the classes or by talking to the college authorities. He also could have learned, if he does not already know, that The Anatomy Act of Ontario was revised in 1950 to provide for the adding of the Canadian Memorial Chiropractic College.



On page 44 and 45 the author is critical of references in the college calendar to dissection as a part of the course in anatomy taught to students in our Canadian College. He states that: "the question of whether the course includes human dissection is left deliberately vague."

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12. ~~Paragraph 12~~ The appropriate section of the Anatomy Act reads as follows, taken from the Revised Statutes of Ontario, 1960, Chapter 14, Section 1:

13. ~~Paragraph 13~~ "In this Act, 'school means the Faculty of Medicine of the University of Toronto, of Queen's University, of the University of Western Ontario, or of the University of Ottawa or the Canadian Memorial Chiropractic College, and includes any other institution that the Lieutenant-Governor in Council declares to be a school for the purpose of this Act. R.S.O. 1950, c.16,1, amended."

14. ~~Paragraph 14~~ Cadavers have been delivered since 1950 to our college at regular intervals, so it will be readily apparent that there was no reason for Mr. Noble to remark that the inclusion of human dissection was "delightfully vague", unless it was his wish to create that impression.

COLLEGE POLICY

Reference:

15. On page 45, paragraph 4, it is stated that the address delivered by B. J. Palmer in our college, was under the sponsorship of our college and that we adhere to the early teachings of B.J. Palmer.

Comment:

16. As a matter of fact the address was sponsored and expenses paid by a group of practitioners who had had some earlier association with the Palmer School of Chiropractic, either as students or in post-



12777 Morgan

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18. Comment:

19. As a matter of fact the address was sponsored and expenses paid by a group of practitioners who had had some earlier association with the Palmer School of Chiropractic, either as students or in post



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graduate study. This group was permitted the use of the auditorium, but the address was not sponsored by our college. Even if it had been, Mr. Noble's deductions are unsound. To imply that the delivering of an address indicates that our policies are based on the opinions of the speaker brings forth some interesting possibilities. Our former Dean, Dr. A.E. Homewood, was invited about two years ago to address the medical students at the University of Toronto on the subject of chiropractic. Does the fact that he accepted this invitation to speak on the premises of the University mean that he was sponsored by the medical faculty and that his teachings form the basis of education in that institution? Such a conclusion would be just as preposterous as that voiced by Mr. Noble.

17. The policies of the Canadian Memorial Chiropractic College are decided by the Board of Directors of our institution which represents the membership in all provincial divisions. Our college represents the successful effort on the part of Canadian chiropractors to establish an educational institution wherein all approved chiropractic techniques will be taught. It is accredited in the United States by the Council on Education of the National Chiropractic Association, a fact which Mr. Noble omitted from his report although he had the information; and in Ontario by the Board of Directors of Chiropractic of this Province.



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BACTERIOLOGY

Reference:

18. On page 46, paragraph 4, line 3, the author states that much double-talk must be called for on the part of the instructor in bacteriology.

Comment:

19. For the information of this Commission, and to refute the supposition of Mr. Noble, we wish to point out that bacteriology is taught at the Canadian Memorial Chiropractic College as a 180 hour course by S. Landi, D.Sc., Ph.D., (Toronto). The subject is taught by this well-qualified member of the faculty in a rational manner, without prejudice and as a necessary basis for adequate diagnostic understanding on the part of the student. The study of bacteriology is as much a part of a well-rounded education for the student of chiropractic as it is for the student of medicine, or osteopathy. Several years ago, prior to our obtaining the services of Dr. Landi on our faculty, the subject of bacteriology was taught by Ronald E. Smith, B.S.A. (Bact.) (Toronto).

COLLEGE EXAMINATIONS

Reference:

20. On page 47, line 11, the statement is made that the requirements for obtaining the diploma of Doctor of Chiropractic do not specify the passing of any examinations in the courses of instruction.



12272 Morgan

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Comment:

21. In the current Calendar of our college on page 10, subsection (c), under "Graduation Requirements", it states that the candidate for graduation must have successfully passed all examinations. Although it may not have been so clearly stated in the 1957-58 Calendar to which Mr. Noble likely referred, nevertheless, we find in that publication a listing of the dates of the semester examinations on page 5. On page 9 under the heading, "General Information For Prospective Students" there appears the following statement, "...the student will be obliged to fulfill the required attendance and the examination standards in that subject before the credit will be granted." It would seem to be quite clear to an open-minded observer that there are examination standards to be met, however, Mr. Noble chose to make a different interpretation. For his records and for the information of this Commission we wish to state that a strict examination standard is maintained and that the overall failure rate between enrolment and graduation is about 40%.

22. It is quite evident from the errors in his report, that Mr. Noble did not consult with the Dean or other officers of the college.

REVISIONS IN CURRICULUM

Reference:

23. In our final point we wish to refer to a statement made to the Commission during the verbal



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Morgan 12781

presentation of the College of Physicians and Surgeons of Ontario. On page 10796 of the transcript of evidence we find reference to the fact that our college enquired regarding the possibility of having physicians teach on our staff and that we had indicated that our curriculum was being revised.

Comment:

24. We would like to clarify this point. For some years the Council on Education of the National Chiropractic Association has been moving toward the development of a uniform curriculum for all accredited chiropractic colleges. During the past year this project reached the stage where certain changes were requested of all colleges. We are currently endeavouring to work these out on a gradual basis so that our course will not be seriously disturbed, but so that we succeed in fulfilling the request of the Council on Education as soon as possible. This re-organization does not represent any major change, but merely an adjustment of times and subjects so that it will be easier to maintain a uniform standard of education and so that student transfers can be accomplished without difficulty.

CONCLUSION

25. We regret the necessity of having to appear before you to refute the inaccurate statements and unjustified suppositions in regard to our educational standards, that have been presented to you. We trust that this presentation has served to



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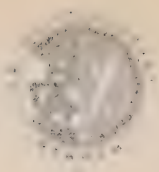
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clear up any points of misinformation and wish to assure the members of the Commission of our continued support in your studies. Our college offices are open to the members of the Commission or your research staff at all times so that up-to-date and factual information will be at your disposal.

Respectfully submitted



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and factual information will be at your disposal.

Respectfully submitted



Morgan 12783

MR. MORGAN: We have submitted our original recommendations in our brief in May, and we are pleased to submit to you the rebuttal, and we are now pleased to present to you the very, very brief summary of that rebuttal. the chiropractic profession would not be

Mr. Chairman and Members of the Commission:

The chiropractic profession in Canada has followed with keen interest the activities of this Royal Commission in its hearings across Canada. We are deeply concerned about certain statements presented during the public hearings and problems which have arisen in the health field subsequent to the appointment of the Commission. We welcome the opportunity of presenting the considered views of the chiropractic profession pertaining thereto. We wish to present at this time a brief summary of our rebuttal submission already filed.

We regret that it has become necessary to be blunt and critical, but we are convinced that it is time to make our position known. We do so in the sincere hope that the recommendations of this Commission will help to overcome the many obstacles which seriously affect the standards of health services of Canadians, particularly insofar as the availability of chiropractors' services is concerned.

The medical profession has stated that chiropractors' services should not be included under a National Health Plan, in fact it has stated that the only program it will support is one in which all persons rendering service are legally qualified physicians and surgeons.



MR. MORGAN: We have submitted our original re-

commendations in our brief in May, and we are pleased to submit to you the rebuttal, and we are now pleased to present to you the very, very brief summary of that rebuttal.

Mr. Chairman and Members of the Commission:
The chiropractic profession in Canada

has followed with keen interest the activities of this

Royal Commission in its hearings across Canada. We are

very interested in the public hearings and problems which have arisen in the

health field subsequent to the appointment of the Commission. We welcome the opportunity of presenting the considered views of the chiropractic profession pertaining thereto.

We wish to present at this time a brief summary of our rebuttal submission already filed.

We regret that it has become necessary to be blunt and critical, but we are convinced that it is time to make our position known. We do so in the sincere hope that the recommendations of this Commission will help to overcome the many obstacles which seriously affect the standards of health services of Canadians, particularly insofar as the availability of chiropractors' services is concerned.

The medical profession has stated that

National Health Plan, in fact it has stated that the only program it will support is one in which all persons rendering service are legally qualified physicians and surgeons.



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4 5. ~~continued from~~ Such statements indicate that medicine
5 considers itself to be the only form of health care
6 necessary for Canadians and that medical care can provide
7 for all of the health needs of all people. If such were
8 the case, the chiropractic profession would not even
9 exist today. On the contrary, chiropractic has grown
10 and developed to its present favourable position of public
11 acceptance and utilization. This is due to the fact
12 that it is a necessary separate and distinct health
13 service not provided by medical care. As stated by the
14 Commission Chairman following the Toronto hearings, "No
15 one phase of health is the complete answer." With this
16 we concur. Chiropractic is a member of the overall family
17 of health services, as is medicine, and we strongly urge
18 that this Commission recommend that chiropractic must be
19 included in any program for improved health care for
20 Canadians.

21 6. ~~the proposed~~ It has been suggested that the medically
22 sponsored prepaid medical insurance plans could well form
23 the basis for a national health insurance plan if govern-
24 ments would subsidize those Canadians presently unable
25 to provide their own insurance. We must object most
26 strongly to such a suggested program, for it would
27 strengthen the medical monopoly in the health care field;
28 it would deny to Canadians the right to chiropractic care
29 or to any form of health care other than medical. It
30 would, in fact, be a surrender on the part of government
of its responsibility to the people of Canada, and the
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recommend that a separate agency be established to administer a health plan; that all recognized health groups be represented on the agency; and that no one group may dominate or control.

7. The Ontario College of Physicians and Surgeons has suggested that it should license chiropractors. After many years of outright medical opposition to chiropractic, such a suggestion can only be interpreted as ample proof of the desire of the medical profession to regulate and control, and eventually eliminate chiropractic by legislative means. The licensing of chiropractors must not be entrusted to the medical profession. We concur with the statement of Walter I. Wardwell, Ph.D., University of Connecticut, that the issue of chiropractic and medicine as systems of therapeutics can never be resolved by legal action or power politics, but must be settled on its merits. We submit that this is being done as evidenced by the growing public acceptance and utilization of chiropractic.

8. We strongly urge that this Commission recommend that recognized branches of the healing arts should maintain their separate autonomy, responsible only to the people they serve and the elected representatives of those people.

9. The most glaring indication of the attitude of the medical profession towards the chiropractic profession is contained in the "Noble Report". Since a copy of this report is in the hands of the Commission, it becomes necessary that we refute the charges contained therein. The Ontario Chiropractic Association



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section of this submission contains the specific answers to the inaccuracies, incorrect assumptions and misleading statements of the "Noble Report". We submit that this report was not prepared as claimed as a "factual study of Osteopathy and Chiropractic", but for the explicit purposes of thwarting chiropractic attempts at improved legislation, discrediting and belittling chiropractic, and in fact, recommending ways and means of dealing chiropractic in Ontario a "knock out" blow.

10. In view of the foregoing, we strongly urge the Commission to entirely disregard the "Noble Report".

11. The conflict between medicine and chiropractic, as evidenced by the continual attempts on the part of the medical profession to eliminate chiropractors; its attempts to monopolize the health care field will serve to lower the standard of health services. The public of Canada is entitled to the best health care available, and we submit that the health needs of Canadians will be best served by a program which provides for the distinctive services of all recognized branches of the healing arts, provided these branches work together in friendly competition and co-operation.

12. The active support and co-operation of all branches of the healing arts and governments at all levels will be required to attain the full potential of improved health services available to Canadians. The chiropractic profession in Canada herewith pledges its wholehearted support.

13. All Canadians recently have been made



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5 the medical profession. Chiropractors have long known
6 and felt this influence. All efforts by the chiropractic
7 profession towards advancement, most notably the numerous
8 attempts to gain legislation in Quebec and Nova Scotia,
9 have met strong medical opposition.

10 14. We strongly urge that medicine should
11 discontinue its policy of opposition towards chiropractic,
12 and instead, adopt a policy of co-operation to effect im-
13 proved health care for Canadians. We would welcome most
14 heartily the co-operation and assistance of governments
15 and the medical profession, to obtain chiropractic legis-
16 lation in unlicensed jurisdictions in keeping with other
17 provinces in Canada.

18 15. The Canadian Chiropractic Association is
19 grateful for this additional opportunity to comment on
20 health services in Canada. We do appreciate the co-
21 operation shown our profession and the members of our
22 delegation by the Commissioners and staff of this Royal
23 Commission and we pledge our continued co-operation in the
24 programs designed to improve the health of Canadians.

25 Respectfully submitted.

26 THE CHAIRMAN: Thank you, Dr. Morgan.

27 DR. MORGAN: Mr. Chairman, if I may call
28 upon Dr. D. C. Sutherland, Executive Secretary of the
29 C.C.A., to present the Ontario Division of the Canadian
30 Chiropractic Association rebuttal.

DR. SUTHERLAND: Mr. Chairman and
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DR. SUTHERLAND: Mr. Chairman and Members of the Commission, in these introductory comments concerning our submission, we wish to point out that the



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first paragraph establishes the relationship between the submission of the Canadian Chiropractic Association, the Ontario Chiropractic Association, the Canadian Memorial Chiropractic College and the Board of Directors of Chiropractic of Ontario, and that we support their comments and recommendations.

2. Our submission is chiefly concerned with refuting evidence submitted to the Commission by the Canadian Medical Association in the form of a report prepared for the College of Physicians and Surgeons of Ontario by the College's solicitor, Mr. Warwick H. Noble, Q.C. The author is the son of Dr. Robert T. Noble, a former Registrar-Treasurer of the College of Physicians and Surgeons, and an outspoken opponent of the chiropractic profession (Paragraphs 2 -4). The report in question is entitled "A Study of Osteopathy and Chiropractic" and is dated December 1958.

3. In the words of the College of Physicians and Surgeons, it is an "exhaustive study assembling all available information". We challenge that statement. Why, in reporting on the chiropractic profession, does the author express his indebtedness only to sources of information within the American Medical Association? The A.M.A. has publicly announced its campaign of outright opposition to the chiropractic profession and its colleges, yet this so-called "factual" document has as its basis, data from this highly prejudiced source.

4. In a book published by the American Medical Association and used by Mr. Noble for reference material, the facts of neurology and physiology are dis-



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torted in order to discredit chiropractic principles. We have dealt effectively with this distortion in our submission (Paragraphs 68 - 77)

5. ~~Interpretation~~ The author's lack of attention to accuracy and detail is particularly well illustrated in the fact that, as a lawyer, he is apparently unfamiliar with the legal status of a chiropractor in a court of law. In implying that chiropractors are not accepted as expert witnesses in court, he is in error, and we have provided a number of examples of such cases in Appendix 11.

6. ~~on 8 to 17~~ In spite of his obvious unfamiliarity with our profession, the author states in the preface that, although authorized to do so, he sought no help other than clerical, and that he, himself, "assembled, analyzed and organized the material and prepared the text of this report". Since normal investigative procedures were thus ignored, and since the author was obviously prejudiced when one considers Dr. R. T. Noble's attitude and Mr. Warwick Noble's reliance on the American Medical Association for information, the veracity of the entire document is hereby called into question.

7. ~~summary~~ In attempting to make the point that chiropractic "licensure has become sheer mockery", (Paragraph 45) Mr. Noble uses New York State as his example; a State where there is no chiropractic license at all, due to the annual opposition to legislation by the medical association. It is true, however, that licensure in that State has been made a mockery, - by the State Board of Medical Examiners. A government probe of this Board was announced on July 28th, 1961, by the State Education



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Department following alleged irregularities in the examining and licensing of physicians. (Paragraphs 45 -46) Evidence will also be introduced by the Board of Directors of Chiropractic of Ontario to show that Basic Science have set out to determine, improperly, the identity of candidates, and then have failed chiropractors who actually passed, and have passed medical candidates who actually failed. Mockery there is; but it would appear to be in fields other than chiropractic.

Mr. Chairman, the following paragraphs from 8 to 17 deal with education, and I would respectfully request that Dr. D. W. Macmillan, Chairman of our College Committee to read this submission.

DR..MACMILLAN: Mr. Chairman, members of the Commission, it was our original intention to present you with a movie picture film to acquaint you with a program that is being done by our Committee, but owing to the lack of darkness in the room we decided to omit doing this. But if you wish to see it, we can do so.

Mr. Chairman, the author of this report is critical of chiropractic education at the turn of the century and states that our colleges of that day were operated for profit without sufficient regard for standards. He also implies that medical standards of that day were satisfactory (paragraph 27). This is typical of the comparisons made by Mr. Noble in that it fails to tell the whole story and leaves the reader with a false impression.

9. The truth is that the early chiropractic colleges followed the pattern laid down by other

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institutions of their time and medical education was anything but satisfactory. According to the report for the Carnegie Foundation for the Advancement of Teaching, prepared by Abraham Flexner in 1910, (Paragraphs 28-31) there was an "over-production of uneducated and ill-trained medical practitioners....". Flexner's report condemned medical education of the period in question and named one of the medical schools in Ontario as being the equal of the worst kind of school found in the United States. He recommended that 80% of the medical schools then in existence should be closed in order to elevate medical standards. This was the environment into which chiropractic colleges were born. During the intervening years, medical institutions have had the aid of government grants to correct this deplorable state of affairs, but out colleges have had to rely upon the support of the profession alone to finance their up-grading program during this time. This casts a far different light upon the subject than that shed by Mr. Noble.

10. His report was prepared for the express purpose of interfering with the proper and legitimate development of the chiropractic profession, and the author made this abundantly clear in the three courses of action which he outlined for the College of Physicians and Surgeons and upon which they could base their policy toward our profession. The three courses of action are described as follows, in Mr. Noble's own words: (Paragraph 100).

11. "(1) Should the College adopt an 'all out offensive' policy and seize the opportunity to give chiropractic in Ontario a



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'knock-out' blow?

(2) Should the College adopt a policy of 'partial offensive' and not only oppose the changes asked for by the chiropractors, but counter with changes that it considers desirable within the framework of the present legislation?

(3) Should the College adopt a policy that is purely defensive and seek only to prevent any changes in the present legislation?"

12. To base a policy decision of this nature upon such a biased report as the one in question would show an utter disregard for truth and no concern for the rights of the individual - a flagrant violation of the high standard of professional conduct that is held before us.

13. The first course of action, or the "knock-out" program, is shown as having fewer disadvantages than other "plans of attack", and one method of accomplishing this feat is "to elevate chiropractic to its own destruction". (Paragraph 103) We would remind the Commissioners at this point that the College of Physicians and Surgeons has suggested to the Commission that they, (the College), should have the authority to license chiropractors. Why? "To elevate chiropractic to its own destruction"?

14. The "Noble Report" also contains several erroneous of references to chiropractic education. The topics covered in these references are found in section 111 of our submission and are:

(a) cause of disease (paragraph 3- 4)

(b) existence of spinal subluxations



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Commission

'Knock-out' blow?

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III of our submission and are:

(a) Cause of disease (Paragraph 8-4)

(b) Existence of spinal subluxations



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(paragraph 5 - 7)

(c) the importance of diagnosis (paragraph 8-9)

(d) teaching of anatomy through human dissection (paragraph 10-14)

(e) College teaching policy (paragraph 15-17)

(f) bacteriology (paragraph 18 - 19)

(g) College examinations (paragraph 20-22)

15. We wish to state most emphatically, that in these seven areas, Mr. Noble has made false and misleading statements. These are dealt with in detail in the body of our submission.

16. The fanatical and unreasoning opposition to chiropractic, expressed throughout the "Noble Report", will serve to indicate to the Commission the extent of the obstacles and difficulties that have beset the chiropractic profession during its early years. The time has arrived when this type of opposition from parties having a vested interest, must cease. It is not conducive to the improving of health services as it saps the resources of those involved and the patient is the final victim.

17. Mr. Noble admits, in discussing a course of action for overpowering the osteopathic profession, (paragraphs 130 - 136), that if the College were to embark upon such a course, failure to find a solution might result in the functions of the College of Physicians and Surgeons being taken over by a department of government, as has happened in the United States. This is an admission that the College of Physicians and Surgeons would have been exceeding its authority in so interfering with

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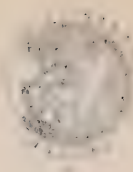
other professions.

Mr. Chairman, to read the recommendations that we wish to make, may I hand this back to Dr. Donald Sutherland.

DR. SUTHERLAND: Mr. Chairman, members of the Commission, the recommendations contained in our report are as follows:

18. (1) Whereas the College of Physicians and Surgeons of Ontario has conducted a campaign for over half a century against the chiropractic profession, and this campaign is described in the "Noble Report" submitted to this Commission; and whereas these "attacks" have failed in their intent, which was to eliminate the chiropractic profession; and whereas the College's solicitor has admitted that to fail in such a campaign might mean that the College's functions would be taken over by a department of government; (Paragraphs 130 - 136), therefore we recommend that the authority of the College of Physicians and Surgeons of Ontario be restricted in such a manner as to prevent its irresponsible and selfish interference in the proper and legitimate development of other professions, (Paragraph 135), including improvements in their legislation; and that the College of Physicians and Surgeons be instructed that they are not responsible for the standards of all who administer to the sick, (Paragraphs 24 - 26), since other professions have their own examining and disciplinary bodies.

19. (2) We recommend that the licensing of members of the healing arts professions be continued as at present, by separate and autonomous boards, composed of



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MR. SUTHERLAND: Mr. Chairman, members

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profession; and whereas the College's solicitor has ad-

mitted that to fail in such a campaign might mean that

the College's functions would be taken over by a depart-

ment of government; (Paragraphs 150 - 156), therefore we

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and disciplinary bodies.

19. (2) We recommend that the licensing of

members of the healing arts professions be continued as at

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members of that profession, each being responsible to the Department of Health.

20. (3) Whereas the chiropractic profession in Ontario is operating at a disadvantage under The Drugless Practitioners' Act, which enables a registrant to hold two separate licenses, thus being responsible to two separate boards, we recommend that the improved legislation submitted to the Department of Health of Ontario by the Board of Directors of Chiropractic of Ontario and the Ontario Chiropractic Association, in 1957, (paragraphs 112 and 136), be passed by the Government of Ontario, thus improving standards and control.

21. (4) We recommend to this Commission (paragraph 51) that the Federal Government should recommend to the provincial governments concerned; principally Quebec and Nova Scotia, but also Newfoundland and Prince Edward Islands; that they take the necessary steps to pass regulatory chiropractic legislation in keeping with the Acts in force in other provinces serving 2/3 of Canadians and in 92% of the United States, and that any professional advice with respect to the preparation of such legislation should be sought from the provincial chiropractic association, with assistance as requested from the Canadian Chiropractic Association, and not from the representatives of organized medicine.

22. (5) Whereas the "Noble Report" admits that a restriction in the Medical Act in Ontario giving physicians "the exclusive right to use the title 'doctor' (Paragraphs 128 - 129) was inserted for the express purpose of denying the use of this title to chiropractors and osteopaths;



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Department of Health.

Ontario is operating as a disorganized mess. The Division
'Practitioners' Act, which enables a registrant to hold
two separate licenses, thus being responsible to two
separate boards, we recommend that the proposed legislation
submitted to the Department of Health or Ontario or the
Board of Directors of Chiropractic of Ontario and the
proposed legislation be passed by the Government of Ontario,
thus improving standards and control.

41. (4) We recommend to this Commission (par-
agraph 51) that the Federal Government should recommend
to the provincial governments concerned, principally
Quebec and Nova Scotia, and also Newfoundland and Prince
Edward Islands; that they take the necessary steps to
pass regulatory chiropractic legislation in keeping with
the Acts in force in other provinces serving 93% of
Canada and in 92% of the United States, and that any
professional advice with respect to the preparation of such
legislation should be sought from the provincial chiro-
practic association, with assistance as requested from
the Canadian Chiropractic Association, and not from the
representatives of organized medicine.

42. (5) Whereas the "Noble Report" admits that a
restriction in the medical act in Ontario giving physician
"the exclusive right to use the title 'doctor' (Paragraphs
124 - 129) was inserted for the express purpose of denying
the use of this title to chiropractors and osteopaths;



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and whereas it is well known that the title "doctor" is not the exclusive property of any group and is not an "occupational designation", but rather a degree, indicative of academic attainment in a variety of fields; we therefore recommend that medicine's "exclusive right to use the title 'doctor'" be revoked, and that this recommendation be forwarded to the Federal Government for passing on to the Government of Ontario.

23. (6) In view of the references to education made in the "Noble Report" we wish to re-emphasize a recommendation presented in our original brief. Whereas the educating and training of students in the healing arts professions is a costly procedure; and whereas educational institutions have great difficulty in operating on donations from the professions and tuition fees alone; and whereas the highest standard of education is a prerequisite to improving health services; and whereas some such institutions have been in receipt of government grants for many years while others have not; we therefore recommend that colleges engaged in the educating and training of members of the healing arts professions should all be placed on an equal basis as far as grants for education are concerned, and that grants for research should also be provided.

24. Finally we would like to make this statement. Sixteen years ago, in 1946, when the College of Physicians and Surgeons of Ontario requested a provincial "Royal Commission" in the hope that they could use its offices to "forestall" the progress of the chiropractic profession, our educational institution was only



and whereas it is well known that the title "doctor" is not the exclusive property of any group and is not an "occupational designation", but rather a degree, indicative of academic attainment in a variety of fields; we therefore recommend that medicine's "exclusive" right to use the title "doctor" be removed, and that this recommendation be forwarded to the Federal Government for passing on to the Government of Ontario.

(d) In view of the references to education made in the "Kobilo Report" as well as to emphasize a recommendation presented in our original report. Whereas the existing and training of students in the healing arts professions is a costly procedure, and whereas educational institutions have great difficulty in operating on a basis from the professions and tuition fees alone; and whereas the highest standard of education is a prerequisite to improving health services; and whereas some such institutions have been in receipt of Government grants for many years while others have not; we therefore recommend that colleges engaged in the educating and training of members of the healing arts professions should all be placed on an equal basis as far as grants for education are concerned, and that grants for research should also be provided.

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one year old. The Canadian Chiropractic Association as a chartered organization did not exist, although provincial legislation had been in force for as long as 39 years. Seven years later, in 1953, our Canadian association was born, but it was not until 1956 that our executive office in Toronto was established. Since that time, in a short span of six years, the Canadian Chiropractic Association has developed into a well-organized body, speaking with authority for the chiropractors of Canada through seven provincial divisions representing all provinces. The profession is united from coast to coast as our presentations to this Commission have demonstrated.

25 87% of the States and Provinces in North America have recognized the services provided by our profession and have passed the necessary legislation which is working effectively (Appendix 1). The other 13% have succumbed to medical pressure and the resulting lack of control makes it possible for unqualified persons to enter the area and open practice. The responsibility for this most undesirable state of affairs rests squarely with the representatives of organized medicine. As long as the medical profession is permitted to assume a position of such influence that it can deprive the chiropractic profession and the people it serves, of their rightful protection under the law, and can cause governments to fail in their duty, which is to see that only qualified practitioners serve the people, then it can surely be said that, quoting Mr. Noble, "licensure has become sheer mockery" (Paragraph 49).



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profession is united from coast to coast as our associations to this Committee have demonstrated. 81% of the States and Provinces in North America have recognized the services provided by our profession and have passed the necessary legislation which is working effectively (Appendix 1). The other 19% have succumbed to medical pressure and the resulting lack of control makes it possible for unqualified persons to enter the area and open practice. The responsibility for this most undesirable state of affairs rests squarely with the representatives of organized medicine. As long as the medical profession is permitted to assume a position of such influence that it can deprive the chiropractic profession and the people it serves, of their rightful protection under the law, and can cause government to fail in their duty, which is to see that only qualified practitioners serve the people, then it can survive he said that, quoting Mr. Justice, "insurance, as become sheer mockery" (Paragraph 45).



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26. The true conclusion to this rebuttal cannot be written at this time. It must await the concerted action of all levels of government aimed at eliminating, in the public interest, the monopolistic tendencies on the part of the senior members of the healing arts and its adverse influence upon the affairs of other recognized professions. (Paragraph 139)

27. We would like to make it quite clear that the critical nature of this presentation is not directed toward the conscientious medical practitioner who is sincerely endeavouring to serve the needs of the people. We note among these physicians an increasing tendency toward inter-professional co-operation. Although this has still not reached significant proportions, we feel that large numbers of medical practitioners will deplore the attitude which has been demonstrated throughout the "Noble Report". We have a duty to our members and the people of Canada to stand firm in the face of such an unjust attack, and to continue to stand firm, in the sure knowledge that our principles are right.

28. We wish to express our appreciation to the Commission for this opportunity of appearing again before you on behalf of the chiropractic profession. In our original submission we pledged that we are prepared to co-operate with all other professions in the healing arts in any program designed to improve the health services available to the people of Canada. We will keep that promise to the best of our ability under these difficult circumstances, and we ask one final question - Will the medical profession and its organizations make the



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before you on behalf of the entire medical profession. In

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that promise to the best of our ability under these

difficult circumstances, and we have one final question

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Sutherland 12799

same promise? (Paragraph 140).

I respectfully submit this report, Mr. Chairman, on behalf of our Association.

THE CHAIRMAN: Thank you, Dr. Sutherland, Dr. Morgan, Dr. Macmillan.

Perhaps this is a very small matter. You purport to quote me as having said something in Toronto on page 11 of your submission, that, "No one phase of health is the complete answer". It is something that may well be said, but I did not say it. The record is to be found on page 12604 of the hearings in Toronto. I was not discussing anything in this context at the time. I say that because it is just as well that the record be right. There is no significance to it otherwise. I was referring to the co-operation we had had from the press and from the other news media, and I said: "This publicity has pointed up the magnitude and complex nature of the whole problem of health services and has served, I think, to dispel the notion that some simple solution or any one plan or program can be accepted without very great study."

Do you wish to add anything further? I know you have made a synopsis of your submissions, and you have done so in very forthright language, and the nature of your presentation here this morning does not appear to call for a great deal of questions; you have spelled out your position crystal clear, and you have made certain requests from your own standpoint which you consider to be proper and have voiced the complaints which you feel are legitimate and which



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should have our attention.

Perhaps I might say this, that in putting so much stress on the Noble Report you have perhaps given it an emphasis that we ourselves have not given to it up to this time. We, as you know, have been conducting an independent study into each of the healing professions, including chiropractic, and that study is being done for the Commission by Dr. Mills, University of Alberta, Calgary campus. I should mention that Dr. Mills probably would not be able to use that in Ontario, from what you have been telling us this morning; he is only a Ph.D. But the whole subject is being studied

(1e) COMMISSIONER FIRESTONE: Dr. Morgan I would like to be enlightened a little on one point which you are making in paragraph 11 on page 6, and I am referring now to the brief of the Canadian Chiropractic Profession. In this paragraph the statement is included:

"Therefore medicine's desire to monopolize this field is not in the public interest. It would slow the advances in methods of health care which would otherwise be brought about through the spirit of competition, a force which medicine has accepted as 'essential' ".

As I understand it Dr. Morgan, the point of view that representatives of the medical profession have been putting forward on the subject you are dealing with is that in taking the attitude they are taking, they



12800

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Morgan

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are not doing it for selfish reasons, to protect their own status or their own profession but they are putting forward the point of view in the interest of the patient. In the interest of assuring that the individual gets the best health care service possible in Canada.

Have you any comments on this sort of point of view that has been put to us?

DR. MORGAN: May I ask you Mr. Commissioner, this interpretation, are you taking that from our statement or from statements that have been made?

COMMISSIONER FIRESTONE: I am not taking it from your statements, but the impression I gathered in talking to representatives of the medical profession is they are not putting the point of view they have been putting forward for selfish reasons, but they are mainly concerned with providing the best health care services to the patient.

DR. MORGAN: As far as this matter pertains to our profession, I believe that the attitude of the medical profession towards the chiropractic profession, down through the years, has been such that they have not certainly approved of chiropractic, so that they are then, with that belief, justified in their minds in taking steps to deny chiropractic and, in fact, to oppose chiropractic, once again in their minds having the best interests of the people of Canada at heart.

COMMISSIONER FIRESTONE: Why would they have this attitude towards the chiropractic profession?



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COMMISSIONER BURNHAM: Why would they

have this attitude towards the chiropractic profession?



Morgan 12802

Do you feel that you are providing an important health service to the Canadian people?

DR. MORGAN: We would very much like to know why this attitude has continued. We do feel that we are providing a necessary service to the people of Canada, and we do feel that the medical profession should see fit to recognize that and co-operate with us, rather than continue the attitude and action of opposition.

COMMISSIONER FIRESTONE: Are you suggesting that you have been unable to get, as a profession, or as an association representing a profession, you have been unable to get from the medical profession the reasons for the attitude they have taken?

DR. MORGAN: They have on occasion stated their reasons. We have on frequent occasions attempted to point out where those reasons are not justified, in our mind.

COMMISSIONER FIRESTONE: What would you say is one of the main points that has been put forward as to why the chiropractic profession is not providing an adequate health care service; without going into detail? I would appreciate there are many ramifications. I would just like one point to illustrate this.

DR. MORGAN: I think the section in the original brief entitled "Chiropractic and Medicine" outlines very clearly the several areas in which the medical profession have denied chiropractic members, and I believe have used this as a justification for their continued opposition.

That same document shows areas in which



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That same document shows areas in which



Morgan 12803

they have utilized and recognized, to a degree, chiropractic principles.

COMMISSIONER FIRESTONE: You feel that your profession is just misunderstood or is there something more basic behind the act of the medical profession towards your profession?

DR. MORGAN: I think, as we said in this submission, that it is an attempt on the part of the medical profession to monopolize the health care field.

They are not prepared to accept the fact that there are other branches in the healing arts, and that the medical care may not be the one and only form of health care in the healing arts.

COMMISSIONER FIRESTONE: You talk of a monopoly. People monopolize something for a self interest. But the medical profession has been telling us, at least that was my impression I should say, that they are doing it in the interest of the patient, not in their own interest.

I am trying to understand you. You claim they monopolize the health care field. They are not doing it to benefit themselves. They are doing it, whatever you claim that they are doing, in the interests of the health care of the Canadian people. What is your issue? In a monopoly somebody tries to help others get the highest possible health care. Is this what you mean by a monopoly?

DR. MORGAN: Maybe not, because we do not feel that this is the first purpose in their attempted monopoly, as we call it. This purpose is, in fact,



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COMMISSIONER WILKINSON: You feel that

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DR. MORGAN: Maybe not, because we do

not feel that this is the first purpose in their attempted

monopoly, as we call it. This purpose is, in fact,



Morgan 12804

to prevent and to interfere with the position of the chiropractic profession in the healing arts.

THE CHAIRMAN: What you are saying is they ought not to be the judge of that?

DR. MORGAN: Very definitely, yes. That puts it very well Mr. Chairman.

THE CHAIRMAN: Because of self interest they ought not to, even enlightened self interest.

DR. MORGAN: I think Dr. Sutherland would like to comment on that.

DR. SUTHERLAND: Mr. Chairman, I believe that Dr. Firestone did touch on a very important point when he mentioned a misunderstanding. There is a strong element of misunderstanding here in the sense that organized medicine seems to have ignored, or failed to recognize the importance of spinal mechanics.

In our original brief we have demonstrated that the spine has been largely ignored in medical teachings, as far as the detailed mechanics of it is concerned. Now medical investigators, in recent years, have proven the importance of our principles, and this is also included in our brief, but this new development has not permeated to the whole medical profession to the extent that they are willing to recognize what we have been doing. I think that is an accurate statement.

COMMISSIONER FIRESTONE: That is a very helpful comment. In that same sentence, that second sentence you refer to competition contributing to advanced methods of health care. What kind of friendly competition do you have in mind between the medical profession



UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR MEDICAL SERVICES

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Morgan 12805

and the chiropractic?

DR. MORGAN: Specifically Mr. Commissioner, there are areas in which the lack of competition acts as a distinct hardship to the people whom we serve particularly in the co-operation pertaining to the reports and findings, and recommendations that have occurred in the health service in the past.

We have great difficulties, in fact, it is literally impossible to obtain x-ray reports on patients who have had medical care and seek chiropractic care.

COMMISSIONER FIRESTONE: Who has control over those x-rays which you cannot obtain?

DR. MORGAN: We are led to understand that the radiologist having taken the x-rays, he has the control over those x-rays.

COMMISSIONER FIRESTONE: Are you saying that if you go to a radiologist, or a patient goes to a radiologist, he cannot have the copy of his x-ray to show to a chiropractor?

DR. MORGAN: This is the information we have.

THE CHAIRMAN: Is that your experience?

DR. MORGAN: It is our experience, definitely, yes.

COMMISSIONER FIRESTONE: Does that apply in every province in Canada?

DR. MORGAN: I do not know if the others here can quote any exceptions. I would say perhaps there might be the very few isolated exceptions. They are so



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might be the very few isolated exceptions. They are so



Morgan 12806

few that you could almost say it does not occur.

COMMISSIONER FIRESTONE: In other words, are you suggesting there is such a thing as a restrictive type of practice of preventing others to pursue their approved profession?

DR. MORGAN: Yes, I do.

COMMISSIONER FIRESTONE: Have you taken any action to deal with this restrictive practice?

DR. MORGAN: We are taking this action here Mr. Chairman.

COMMISSIONER FIRESTONE: You are bringing it to our attention, but have you taken any other action in the terms of protesting to the Provincial Government or the Federal Government?

DR. MORGAN: There have been statements at previous hearings to this effect. Dr. Sutherland has something in that regard.

DR. SUTHERLAND: Mr. Commissioner we have approached, for example, the Department of Veterans Affairs to help them in their requisition for chiropractic care for veterans but we were unsuccessful in obtaining this. Perhaps a comment with regard to this problem would be appropriate from the hearings of the Veterans Affairs Committee of the Federal Government on March 10th, 1960, at which time two of our representatives appeared before the Veterans Affairs Committee and the medical representative when questioned by one of the members of the Committee made the statement "I am advised by the spokesmen for organized medicine that it is regarded as unethical to associate with a chiropractor in the



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31 by the spokesmen for organized medicine that it is re-

32 garded as unethical to associate with a chiropractor in the



Sutherland 12807

treatment of a patient or to refer patients to him."

This was the statement made to the Committee.

He then goes on to say "The field of medicine has accepted strange bed fellows all along, and the pattern of practice has changed; but in sixty years, so far, orthodox medicine has not found anything in the practice of chiropractics which it can absorb itself."

COMMISSIONER FIRESTONE: Have you brought this example of restrictive practice to the attention of the Department of Justice?

DR. MORGAN: No, I do not believe we have done that.

MR. BURTON: No.

COMMISSIONER FIRESTONE: Thank you very much gentlemen.

THE CHAIRMAN: I am interested in this statement in paragraph 13 of the summary, also in the brief, this idea of elevating chiropractic to its own destruction. Do you see any possibility that chiropractic might become a specialty in medicine?

DR. MORGAN: I believe Mr. Chairman that it all revolves about the interpretation of the word "medicine". If medicine is used as a term to encompass all branches of the healing arts, then I would say chiropractic is a specialty, as a branch of that but we prefer to use the term medicine as a term denoting the care given by medical doctors.

THE CHAIRMAN: We cannot all quote our own definition of terms. Assuming that chiropractic is a healing art, and is something that ought to be per-



12207 Sutherland

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Morgan 12808

mitted and ought to be fostered and made available to the public, just as the neurosurgeon or the orthopedic surgeon and so forth, et cetera is, is one possible solution to this that chiropractics might be brought within a healing profession that would include more than just medical doctors?

DR. MORGAN: I think that could work, providing it fulfills some of the qualifications we state in our summary that the overall organization, or whatever name you put to it, is not dominated by any one group.

THE CHAIRMAN: You say that basically your educational process qualifies you in various fields just as effectively as the doctor's education?

DR. MORGAN: Yes.

THE CHAIRMAN: In the basic sciences and so forth, et cetera, so then we go on into a separate field as though chiropractic could exist by itself, independent of medicine.

DR. MORGAN: No, definitely not. This is not our position Mr. Chairman.

We fulfill a need in the healing arts as well as the other branches which likewise are in the health care field. That means there must be that recognition and co-operation between all of those branches and in that respect, we certainly feel a part of the overall picture.

THE CHAIRMAN; But this idea, or this notion of elevating chiropractic to its destruction and bringing it within the profession as a specialty of the profession would not destroy the utility of the man, the



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name you put to it, is not dominated by any one group.

THE CHAIRMAN: You say that basically

your educational process would be in various fields

of the health care field, is that correct?

DR. MORGAN: Yes.

THE CHAIRMAN: In the broadest sense

of the health care field, is that correct?

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Morgan 12809

usefulness of the man who was rendering that service to the patient who needed it?

DR. MORGAN: I do not believe that is what is implied in this section. Dr. Sutherland can perhaps say something.

THE CHAIRMAN: Oh I quite understand that. There may be something in the thought that could be developed.

DR. MORGAN: We would hope so.

THE CHAIRMAN: Just as the osteopath in California, apparently, is getting very close to the medical profession and being admitted to practise medicine, at least the graduates of one college.

DR. MORGAN: I believe Dr. Macmillan could perhaps speak on that?

DR. MACMILLAN: Mr. Chairman that is perfectly true that the evolving of the osteopathic profession into the medical profession has caused it to approximate it more particularly in California, as you have pointed out.

There is one osteopathic college in the United States that gives the degree of M.D. You are quite right.

THE CHAIRMAN: I know that we are, shall we say, in the final formative stage, but in a general way this may well be the course that ought to be followed. Somebody ought to say well now boys instead of standing there slugging at one another, should you not find a way of both going down the road; the chiropractor helping the patient just as his neurosurgeon helps him?



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Sutherland 12810

DR. SUTHERLAND: Mr. Chairman there was a Royal Commission, a study of the natural healing arts in Western Australia which presented their report in August, I believe, of 1961 and the Commission at that time said that the ultimate goal should probably be just what you have described but it was impossible at the moment because of the severe conflict between the views of the two professions and that they would hope that we would work towards this unity but at the moment they recommended the establishment of a separate college of chiropractic in Western Australia and separate legislation.

THE CHAIRMAN: I imagine Dr. Mills has had access to that report. That is the kind of thing that he was asked to do; to find out just what the situation really was.

DR. MORGAN: I think this situation could work out in an ideal state but as long as the attitude and the position of the medical profession remains as it is towards our profession, it cannot work out to the benefit of the people under the present situation.

COMMISSIONER VAN WART: There is just one question I want for information. Are you in a position to make a rough estimate of what is the percentage of the population utilizing chiropractic services in Canada?

DR. MORGAN: I believe that information is contained in our brief.

COMMISSIONER VAN WART: What is the percentage, roughly?

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COMMISSIONER VAN WART: What is the

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Morgan 12811

DR. MORGAN: I would have to refer back to the original brief.

THE CHAIRMAN: Perhaps you could reach it another way: What is the number of chiropractors in Canada?

DR. SUTHERLAND: Just over eleven hundred.

DR. MORGAN: I may have to stand corrected, but it seems to me the figure was in the neighbourhood of one million Canadians seek chiropractic care every year.

COMMISSIONER VAN WART: That is what I wanted to know.

THE CHAIRMAN: You have, you say, eleven hundred. There are 17,000 practising medical doctors?

DR. MORGAN: Yes.

COMMISSIONER BALTZAN: Just one question. You referred to the availability or unavailability of the x-rays that you wanted to procure. Not all doctors of medicine read x-rays. My question to you is have you in your profession men who are specialists in radiographic diagnosis or do you all read and interpret x-rays that you obtain?

DR. MORGAN: May I ask Dr. Macmillan, who is President of our x-ray council to answer that?

DR. MACMILLAN: Mr. Commissioner there is within the chiropractic profession a system of certifying chiropractic radiologists, as such. May I make it clear that the word "radiology" is used prefixed by chiropractic.



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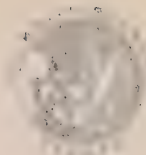
Macmillan 12812

The examination of the structural and postural film is somewhat different for the radiologist in the medical profession looking for pathological changes in the tissue who would examine the film. These men have passed a very rigid, a very rigid set of examinations conducted by a Board of Examiners. If they are successful, they are given the designation as certified chiropractic radiologists.

COMMISSION BALTZAN: In what way, in the form of instruction do you differ, if you differ in your interpretation of film from these men who are known as medical radiologists?

DR. MACMILLAN: I am speaking now of structural changes as opposed to pathological changes. For example, the medical doctor would be more inclined to cause an exposure to be made of the patient in a reclining position, because he is looking for some pathological change. The chiropractor would be concerned with examining that person in the upright position because we look for structural distortion. The radiographs are made giving the ability to recognize the departure from normal, which would be pathological, and then the service of the medical radiologist would be enlisted in the interpretation of that pathology. Our men are well versed, as members of the Canadian Council of Chiropractic Roentgenologists to recognize a departure from normal but they are not, of course, holding themselves out to be radiologists as such to determine what that departure would be called.

COMMISSIONER BALTZAN: That also includes



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Macmillan 12813

necessarily, that strict attention be paid to recognizing anything that is not normal, or pathological. You speak of structural alignment and yet you say that your people are not trained, or not given to pay attention - I am not putting words in your mouth. You help me out. You do pay attention to the recognition of pathological departures?

DR. MACMILLAN: Yes. Now I say, as you are probably quite aware, the specialty of radiology within the medical profession is a five year course, graduate course.

COMMISSIONER BALTZAN: That is what prompts my question.

DR. MACMILLAN: The members of the medical profession who are not radiologists do not hold themselves out to be, and we do not hold ourselves out to be radiologists in the comparable pathological interpretation of the films as it is with specialists in radiology.

COMMISSIONER BALTZAN: Would these x-rays be suitable for you if they were taken by the medical radiologists? He would not be posturing them the way you do.

DR. MACMILLAN: Except in some isolated cases - the word "isolated" is too confining possibly - it has been my experience that when the low back is involved and the patient reports to the medical doctor, the radiologist is instructed to expose his radiograph in the upright posture and so there is this drift towards the understanding that the spine, being a flexible column,



Macmillan 12813

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Macmillan 12814

will show distortion when it is made to bear weight. I would like to look upon it as acceptance in very simple terms of what we have held for years.

COMMISSIONER BALTZAN: Thank you very much.

THE CHAIRMAN: Thank you very much Mr. Morgan and your associates.

DR. MORGAN: Thank you Mr. Chairman. We once again appreciate the opportunity of appearing before you.

THE CHAIRMAN: Now we have one other brief of the Chiropractic Board of Directors. I understand this is quite short. If you would prefer to finish it right now; we will do so.



12814 Hamilton

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Beasley 12815

SUBMISSION

BY

THE BOARD OF DIRECTORS OF CHIROPRACTIC

Drugless Practitioners Act

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APPEARING IN PARAGRAPH

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2. Page 16, Annual Report, College of
Physicians and Surgeons of Ontario,
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THE BOARD OF DIRECTORS OF CHIROPRACTIC
Druggists Practitioners Act

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	Transcript of hearings, pages 10798-10802,
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	APPENDICES
32	1. "Information for Chiropractors"
36	2. Page 16, Annual Report, College of
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- (1) The Board of Directors of Chiropractic (herein after referred to as "The Board" or "This Board") is the Government-appointed examining, licensing and regulatory Board for all chiropractors in the Province of Ontario. This statutory body controls the practice of chiropractic in this Province.
- (2) The Board functions under authority of The Drugless Practitioners Act, R.S.O. 1960, Chapter 114, as amended by The Drugless Practitioners Amendment Act, 1961-62, Chapter 36, and the regulations made under authority of this statute. Responsibility is to the Ontario Minister of Health, and the Department of Health. All regulations by the Board are made with the approval of the Lieutenant-Governor in Council.
- (3) A detailed outline of the duties and functions of this Board may be found in submission #287 by the Canadian chiropractic profession, Ontario Chiropractic Association Brief, pages 3 to 7, paragraphs 12 to 43 inclusive.
- (4) The purpose of this rebuttal presentation has to do with certain factual inaccuracies, distorted implications or conclusions, and charges of incompetency to be found in submissions and oral remarks made to this Royal Commission concerning matters which are within the purview of this Board.
- (5) In addition, it is our intention to furnish accurate information, to thereby bring differing conclusions based on the whole area of discussion rather than on segmental emphasis.



ONTARIO, CANADA

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Reference is now made to the submission of The College of Physicians And Surgeons of Ontario, May 22nd, 1962, as Exhibit # 298.

Statement, Page 3, Exhibit # 298, 3.2 Control of Registered Medical Doctors:-

"... The courts have repeatedly held that what constitutes this sort of professional conduct by a licensed practitioner is properly the judgment, after a fair hearing by his peers, i.e. the Council of the College. We are of the opinion that this is right and that fair-minded members of the profession are the only groups qualified to decide what is and what is not proper conduct of a member of the medical profession and no charge is necessary or advised in this matter."

Comment:-

(6). The College recommends no change in its disciplinary power. Nevertheless, later in its submission the College recommends that all healing come under its jurisdiction and control. If the College's desires in this respect were implemented, this would negate "...the courts have repeatedly held that what constitutes ... is properly the judgment, after a fair hearing by his peers ...".

(7). A chiropractor is equally entitled to be judged by his peers on professional matters. Courts of law have held that medical practitioners are not the peers of chiropractors.

(8). From 1926 to 1952, a registrant under The Drugless Practitioners Act was not disciplined



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Beasley

as Exhibit # 298.

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Registered Medical Doctors:-

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the peers of chiropractors.

From 1920 to 1922, a registrant under

The Druggists Practitioners Act was not disciplined



exclusively by his peers, but by a Board of Regents made up of representatives of at least three other groups, all registered under the Act. In 1952, with the formation of various Boards of Directors, this situation was corrected.

Statement, Page 4, Exhibit # 298, 3.3 Control of Auxiliary Medical Bodies

This paragraph discusses auxiliary and para-medical groups.

(9). The chiropractic profession cannot be correctly designated as an auxiliary medical body or other para-medical group, since the profession operates as a separate entity in the healing field.

Statement, Page 4, Exhibit # 298, 3.4 Licensing under the D.P.A. (items a to e)

It appears that the remarks directed under this paragraph (items a to e) as well as those contained in the Conclusions and Recommendations are intended to include chiropractors, since legally qualified chiropractors form the majority of registrants under this Act.

Statement (a):-

"There are groups who do not accept that the standards as established by Legislation through the Medical Act are either correct in their concept or necessary to carry on the healing art."

Comment:-

(10). Identical standards are neither necessary nor correct, since, by legislation, legally qualified chiropractors do not prescribe drugs, practice surgery

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or midwifery.

(11). A valid reason for opposition by the chiropractic profession to inclusion of chiropractors under The Medical Act is the survival of an art necessary for the public welfare, and for this art to be carried on without unnecessary interference.

(12). Medicine's desire to control all healing arts groups is, in the opinion of the chiropractic profession, primarily one of self interest and self protection under the guise of public interest.

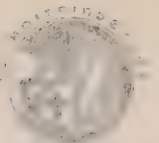
(13). Legislators, throughout North America and in other countries, have found legislation separate from their medical practice acts to be the most effective means of regulating chiropractic, while at the same time avoiding undue hindrance or harrassment, as well as protecting the public interest.

(14). The question of control of chiropractic and other groups came in for considerable attention in this Province in 1923.

(15). At that time, the medical profession demanded that Premier Drury enact a new definition for the practice of "medicine" which would make it impossible for any non-medical groups to practice in the Province.

(16). The following excerpts, from Toronto newspapers of January, 1923 give a clear view of the intent:-

"... submitted to Premier Drury by the Ontario Medical Association ... the Association also 'feels impelled to urge that chiropractors should be given



12819

General

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Beasley 12820

no consideration in law'."

"The sects which it is particularly desired to control are the chiropractors and osteopaths, and the registered physicians were anxious at last evening's meeting that they should be promised the validation of a definition of the term 'practice of medicine', which would prevent entirely the operations of these healers. Premier Drury would not undertake to introduce legislation validating the definition which was proposed. The regulation of these healers, he pointed out, presented a peculiar problem of Government."

"Bar Chiropractors, Doctors Tell Drury. Wage Bitter War Against Competitors in Interview with the Premier. Medical men of the province waged bitter war last night against all those who ministered to the sick professionally, and who did not have an education equivalent to that which the law required of the physician. The most eminent physicians and surgeons, to the number of 50, from every section of the province, interviewed Premier Drury and his cabinet to seek adoption of their definition of 'medicine', and to have practitioners who did not come within the scope of their definition prevented from practising."

(17). In brief, out of this bitter controversey, came the recognition by legislators of the need for varying requirements and thus The Drugless Practitioners Act of 1925.



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(17). In brief, out of this bitter controversy

came the recognition by legislators of the need for

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ers Act of 1935.



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Statement (a):-

"They, however, aspire to the privileges which can only be carried out with safety in the hands of, or under the direction of, those who have spent long years of study and demonstrated their ability to meet the arduous course of training as established and maintained under the Medical Act."

Comment:-

(18). Ontario chiropractors do not aspire to the use of drugs, surgery or midwifery. Chiropractors have no quarrel with the view that anyone practicing health care by the use of drugs or practice of surgery or midwifery should meet the requirements of The Medical Act. Chiropractors are trained to safely administer health care within their practice rights. It is incorrect to imply otherwise.

(19). The course of study and clinical training required for license to practice chiropractic in the Province of Ontario can also be described as long and arduous, and is comparable to that of other health practitioners, all relevant matters being taken into consideration.

Statement (a):-

"Such groups lack appreciation of their own limitations and tend to apply their concepts beyond their knowledge and abilities, and under such circumstances, constitute a direct threat to 'life and limb'."

Comment:-

(20). The opinion of physicians as to the

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assessing

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limitations, concepts and abilities of chiropractors varies from 'gross and pitiable ignorance' (at the Association level), to respectful co-operation (on the individual level), and even including use of chiropractic methods.

(21). The basis for chiropractic has been scientifically established.

(22). Adherence to the system of treatment permitted chiropractors by law assures the protection of the patient. This is one of the duties of this Board. During the past ten years, it has been only on rare occasions that the Board has had to deal with chiropractors going beyond their scope of practice.

Statement (b):-

"It is not the concept of the College that anyone should be prohibited from making useful contributions to the healing art. The College does, however, believe that everyone should first be required to pass through the regular course of study as established and maintained by the Medical Act, following which they would have the knowledge and experience to enable them to recognize such situations as may become apparent and deal intelligently with them. The College does not wish to exclude experimentation and new concepts but are of the opinion that it is most difficult to isolate and deal with 'quackery' and the dangers of 'a little knowledge', especially in the hands of those who lack adequate training in the field of the basic sciences, medical therapeutics and proven acceptable



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experimentation."

In essence, this statement suggests
and assumes that:-

1. All healing comes under the benevo-
lent superintendence of the medical
profession.
2. All those responsible for, and
providing health care, should pass
through the course in medicine and
graduate as a physician.

Comment:-

(23). Regulation and control of health practi-
tioners is the responsibility of Government, and not
exclusively that of any one group in the healing field.

(24). In some cases where the responsibility
of Government in all health matters has been given
over to medical domination and control, the authority
has been abused.

(25). In the context of the College's reason-
ing, dentists would be required to take a complete
medical course prior to entering on the study of
dentistry.

(26). The curriculum of an accredited chiro-
practic college provides the knowledge and experience
for the chiropractor to recognize and deal intelligently
with patients coming to him for care.

(27). Medical training is no more guarantee
against 'quackery' and 'a little knowledge' or direct
threats to 'life and limb' than training in any of
the other healing fields.

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threats to 'life and limb' than training in any of

the other healing fields.



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Statement (c), page 5:-

"This concept is constantly and rigidly applied in the matter of ordinary education. There is but one path leading to what is called 'matriculation' and no circumvention is tolerated. Surely, if such standards are so essential at this early and less personalized stage in general education, it is not expecting too much that we should guard equally the health and welfare of our population by requiring that everyone aspiring to participate in the healing art shall meet the standards which are generally accepted. If, after such a course of training, anyone wishes to advance some particular idea, they will have the background and training to enable them to bring to their endeavours a full range of existing knowledge and experience."

Comment:-

(28). Matriculation is designed as a basic and generalized preparation for entrance into specific fields of endeavour and service such as law, medicine, nursing, dentistry, the other healing arts, economics, commerce and industry, social services, etc.

(29). Immediately beyond the matriculation level, differentiation of courses begins, as in arts, pre-dental and pre-medical courses.

(30). Applying the line of reasoning used by the College to religious education would require a clergyman, priest or rabbi to have identical training --- yet all minister to religious needs.



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"This concept is constantly and rigidly applied in the matter of ordinary education. There is but one path leading to what is called 'higher education', and no circumlocution is tolerated. Surely, if such standards are so essential at this early and less personalized stage in general education, it is not expecting too much that we should guard equally the health and welfare of our population by recognizing that everyone aspiring to participate in the healing art shall meet the standards which are generally accepted. If, after such a course of training, anyone wishes to advance some particular idea, they will have the opportunity and training to enable them to bring to their endeavors a full range of existing knowledge and experience."

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Statement (d), page 5:-

"For the welfare and safety of the public as a whole, if there is to be licensing to practise in the field of the healing art outside the originally established channel, those doing so should be very strictly limited to closely defined areas of treatment as set out in the Act under which they operate, and they should be held strictly responsible for the consequences of departing from such restricted areas."

Comment:-

(31). What legally qualified chiropractors are licensed to do in Ontario is to be found on page 6, paragraphs 33 to 37 inclusive of the Ontario Chiropractic Association Brief presented to this Royal Commission, May 1962 and is as follows:-

"33. License (certificate of registration) to practice chiropractic, within the scope laid down in the Act and regulations, is issued providing the foregoing requirements have been met, and registration fee of \$40 is paid.

"34. By Section 1 (b) of The Drugless Practitioners Act (R.S.O. 1960, Chapter 114), registrants may practice the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electrotherapy or by any similar method.

"35. By Section 7 of The Drugless Practitioners Act (R.S.O. 1960, Chapter 114), registrants may not prescribe or administer drugs for use



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"35. By Section 7 of The Progress Practitioners Act (R.S.O. 1960, Chapter 114), registrants may not prescribe or administer drugs for use



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internally or externally or use or direct
or prescribe the use of anaesthetics for any
purpose whatsoever or practise surgery or
midwifery.

"36. By R.R.O. 119/60, 1 (2), - (This should have
been correctly shown as R.R.O. 120/60) -

The system of treatment that may be followed
by chiropractors is the treatment of persons
by the relief of interference with the
normal functioning of the nervous system of
the body by the adjustment or the manipula-
tion or both of the articulations and the
tissues thereof, more especially those of
the spinal column, and when necessary with
the aid of

- (a) exercise,
- (b) light,
- (c) thermotherapy,
- (d) hydrotherapy, or
- (e) electrotherapy.

"37. Scope of practice is subject to provisions
of the following other Provincial statutes
relating to the treatment of human ailments:-
The Public Health Act, The Vaccination Act,
The Vital Statistics Act, The Venereal
Diseases Prevention Act, The Workmen's Com-
pensation Act."

(32). A study of the foregoing will reveal
that chiropractors in Ontario practice subject to
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- (b) light,
- (c) therapy,
- (d) electrotherapy, or
- (e) radiotherapy.

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The total effect of these restrictions narrows the field of the practicing chiropractor. Since these restrictions are contained in a number of statutes, this Board furnishes all chiropractors with a summary of applicable legislation. The current edition of "Information For Chiropractors" is attached for your information as Appendix 1.

(33). A chiropractor is responsible if he departs from these defined limitations. This Board takes disciplinary action with its powers.

Statement (3), page 6:

"The system established in 1866 and continued by The Medical Act of 1869, continues to serve well the purpose of protecting the public in so far as it is applicable. There is, however, some reason for concern by virtue of the acceptance of multiple standards of education and control."

Comment:

(34). The question of education has been covered above.

(35). In regard to control, it is quite true that in Ontario there has been, in some respects, some lack of control of chiropractors - mainly relating to advertising.

(36). This Board and the Ontario Chiropractic Association attempted for many years to obtain controlling legislation. In 1957, representations were made for legislation to improve administration and control advertising. The result of these representations, instead of being welcomed as an improvement in control,

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was the preparation of a report by Warwick H. Noble, Q.C., dated December 1st, 1958 on instructions of The College of Physicians and Surgeons of Ontario (see Appendix 2). It is believed that a copy of this report (The Noble Report) has been made available to the Commission.

(37). Paradoxically, this Board was denied control of this troublesome situation, and yet was powerless to act upon complaints received from The College of Physicians and Surgeons regarding advertising.

(38). This Board was more than pleased that the Minister of Health this year introduced legislation amending The Drugless Practitioners Act which permits this Board to establish adequate advertising control (The Drugless Practitioners Amendment Act, 1961-62, Chapter 36). Suitable regulations are pending.

(39). That this legislation was introduced by the Minister of Health on the request of this Board is evidenced by the following statement from page 1800, Ontario Legislature report, April 2, 1962:-

"The Drugless Practitioners Act

"Hon. Mr. Dymond moves second reading of Bill No. 109, An Act to amend The Drugless Practitioners Act.

"Hon. M. B. Dymond (Minister of Health): Mr. Speaker, I would like to say something on this bill just to clear up a very gross misunderstanding. This bill was introduced by request of the board of examiners of the chiropractic group,



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it was not a government imposed measure as was reported in the newspapers.

"Motion agreed to; second reading of the bill."

(40). One problem of control which remains unsolved is that of dual registration wherein some chiropractors are also registered as drugless therapists under The Drugless Practitioners Act. Disciplinary problems arise when a registrant claims to have done something within his practice rights as a drugless therapist rather than as a chiropractor.

(41). Removal of the chiropractic profession from The Drugless Practitioners Act by means of a separate Chiropractic Act as proposed in 1957 would alleviate much of this problem. This Act should make a chiropractor under a Chiropractic Act responsible for all his professional ministrations.

Statement, Exhibit # 298, Conclusions and Recommendations, Page 21:-

"The College recommends that health matters remain under provincial jurisdiction and that the present functions of the College be continued and, that in co-operation with the provincial legislature, the problem of licensing to practise the healing art be studied as required with a view to assuring that those permitted to practise any part of health or medical care shall have at all times such basic training as will assure their ability to recognize their own limitations and that they possess adequate knowledge to deal competently with any emergency or threat to life which may arise out of any responsibility they



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(41). Removal of the chiropractic profession

from The Druggists Practitioners Act by means of a separate Chiropractic Act as proposed in 1957 would alleviate much of this problem. This Act should make a chiropractor under a Chiropractic Act responsible for all his professional ministrations.

Statement, Exhibit # 108, Recommendations and Recommendations-

ions, Page 21.

"The College recommends that health

matters remain under provincial jurisdiction and that the present functions of the College be continued and that in co-operation with the provincial legislature, the problem of licensing to practice the healing art be studied as required with a view to assuring that

those permitted to practise any part of health or medical care shall have at all times such basic training as will assure their ability to recognize their own limitations and that they possess adequate knowledge to deal competently with any emergency or to treat to life which may arise out of any responsibility they



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may undertake."

Comment:-

(42). On the matter of a study of licensing to practice the healing art, the College suggests that it carry out such a study "in co-operation with the provincial legislature". In view of past history in Ontario (as outlined elsewhere), it is improbable that an impartial study by The College of Physicians and Surgeons, with unbiased conclusions, would result.

(43). This recommendation is a repetition of that made by The College of Physicians and Surgeons in 1946, 1947 and 1948 requesting a Royal Commission to "report on all phases of medical education". At that time, the intention and purpose was to "forestall" chiropractic progress. (See Noble Report, Page 10, paragraph 2).

(44). Educational standards required for license to practice chiropractic in Ontario have been under continuing study and improvement over the years. As examples, the course of study was increased to four years of eight months each in 1935, to four calendar years of nine months in each year in 1937, preliminary educational requirements of Honour Matriculation was requested in 1957 and regulations were finally passed requiring this in 1961.

(45). When the proposal "that they possess adequate knowledge to deal competently with any emergency or threat to life which may arise out of any responsibility they may undertake" is viewed realistically, it will be appreciated that no practitioner



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(45). When the proposal "that they possess

adequate knowledge to deal competently with any emergency or threat to life which may arise out of any responsibility they may undertake" is viewed realistically, it will be appreciated that no practitioner



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in the healing field possesses sufficient all-encompassing skill to meet such a requirement. However, if "to deal competently with" is interpreted as including consultation and referral of patients where necessary, the chiropractor is trained so to do.

Reference is now made to the verbal statements by the representatives of The College of Physicians and Surgeons of Ontario, May 22nd, 1962, pages 10793 to 10802.

(46). May of the statements contained in this verbal presentation are a repetition of statements made in the College's written submission, Exhibit # 298.

(47). The following comments are restricted to those matters not previously commented upon in this submission.

Statement: - (Page 10793)

"Over the years there has developed various cults within the healing art, and when the College was established there were special cults within the profession itself, for which provision was made for representation on the Council of the College. The homeopaths."

Comment:-

(48). This statement draws attention to the system of minority representation wherein differing professional groups are dominated by one group - the current majority group.

(49). This system as it applies to chiropractors has been widespread, and has taken on many forms such as:-



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passing skill to meet such a requirement. However, it
"to deal competently with" is interpreted as including
consultation and referral of patients where necessary,
the chiropractor is trained so to do.

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representatives of The College of Physicians and
Surgeons of Ontario, May 19th, 1952, pages 10-13 to
10802.

May of the statements contained in this
verbal presentation are a repetition of statements
made in the College's written submission, Exhibit A 200.
The following comments are restricted

to those matters not previously commented upon in this
submission.

Statement - (Page 10-13)

"Over the years there has developed
various units within the healing art, and when the
College was established there were special units within
the profession itself, for which provision was made
for representation on the Council of the college.
The 'homoeopaths'."

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This system as it applies to chiropractors
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1. Medical board composed solely of medical practitioners responsible for licensing all practitioners in the healing field. This is sometimes referred to as a "healing arts board".
2. Mixed board - the majority on this type of board are medical practitioners but with some minority group representation. This may also be referred to as a "composite board".

(50). This system violates the principle of being judged by one's peers. The unfairness of such a system to a minority group is obvious. It is an attempt to stifle and fit all into a common mold wherein minority groups are subjected to the unfriendly attention and outright opposition of the majority.

Statement:- (page 10794)

"More recently we have been faced with the problem of how can we maintain a high standard of quality in everybody who goes into the field of practising the healing art..."

Comment:-

(51). We must reiterate that legislation and control is the prerogative of Government, and that The College of Physicians and Surgeons have been delegated the disciplinary and licensing control of medical practitioners only. Other healing arts groups such as dentists, chiropodists, optometrists, chiropractors, osteopaths, etc. have had disciplinary and licensing powers delegated to them.

(52). Therefore, it is presumptuous of The College of Physicians and Surgeons to consider them-



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practitioners in the healing field. This is

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a system to a minority group is obvious. It is an

attempt to stifle and fit all into a common mold where

in minority groups are subjected to the majority

attention and outright opposition of the majority.

Attachment: (page 10704)

"More recently we have been faced with

the problem of how can we maintain a high standard of

quality in everybody who goes into the field of

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osteopaths, etc. have had disciplinary and licensing

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selves "faced with the problem of how we can maintain a high standard of quality in everybody who goes into the field of practising the healing art."

(53). This Board has been given the responsibility of administering the Act and regulations relating to chiropractors. It makes recommendations for improvement, and has maintained a high standard of training requirements.

Statement: (page 10796)

"Recently the college was asked, in response to a request or a suggestion by the Chairman of a Coroner's Committee, the suggestion was made that chiropractors should be trained sufficiently that they would be able to recognize the dangers inherent in certain situations."

Comment:

(54). This statement probably refers to the report of a Coroner's Jury at Georgetown, Ontario, October 25th, 1961, investigating the death in hospital of a patient from an overdose of insulin. The patient had been under chiropractic care for some months prior to hospitalization. The recommendation by the foreman of the jury that chiropractors should be trained sufficiently that they would be able to recognize the dangers inherent in certain situations, was apparently based on the incorrect assumption that all chiropractors would have rendered care identical to that in this instance. Such an erroneous conclusion is possible only in a hearing or inquest of this type, since no expert witnesses on chiropractic were called.

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(53) This Board has been given the respon-

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Statement: (page 10700)

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Comment:

(54) This statement probably refers to the

report of a Governor's Jury at Georgetown, Ontario, October 25th, 1961, investigating the death in hospital of a patient from an overdose of insulin. The patient had been under chiropractic care for some months prior to hospitalization. The recommendation by the forum

of the jury that chiropractors should be trained sufficiently that they would be able to recognize the dangers inherent in certain situations, was apparently based on the incorrect assumption that all chiropractors would have rendered care identical to that in this instance. Such an erroneous conclusion is possible only in a hearing or report of this type, since no expert witnesses on chiropractic were called.



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Subsequently, the chiropractor involved was charged under Section 51 of The Medical Act and he pleaded guilty. In addition, this Board took disciplinary action, following a hearing. It was determined by this Board that the chiropractor had been negligent in one important aspect of chiropractic care of the patient.

Statement:- (page 10796)

"...Following that suggestion, -
(i.e. the recommendation by the foreman of the Coroner's Jury as referred to above) - we received a communication from the chiropractors' school here in Toronto that we should permit doctors to teach on their staff. We in turn wrote and asked them for their curriculum, the curriculum of their basic sciences, and what facilities they had for teaching these subjects. To date we have not had an answer from them. We had an answer, I am sorry, but the answer implied that they were re-organizing their curriculum, and as soon as it was ready we would have it."

Comment:

(55). The request for information and the recommendation by the foreman of the Coroner's Jury were not related in any way.

(56). The Canadian Memorial Chiropractic College had requested this Board to obtain certain information relating to a possible faculty appointment. A letter was sent, following a telephone conversation, to the Registrar-Treasurer of The College of Physicians and Surgeons dated October 31st, 1961 stating in part:



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Subsequently, the chiropractor involved was charged under Section 81 of the Medical Act and he pleaded guilty. In addition, this Board took disciplinary action, following a hearing. It was determined by this Board that the chiropractor had been negligent in one important aspect of chiropractic care of the

Statement:- (page 10736)

...Following this suggestion,

(i.e. the recommendation by the Foreman of the Coronary Jury as referred to above) - we received a communication from the 'Chiropractors' School here in Toronto that we should permit doctors to teach on their staff. We in turn wrote and asked them for their curriculum, the curriculum of their basic sciences, and what facilities they had for teaching these subjects. To date we have not had an answer from them. We had an answer, I am sorry, but the answer implied that they were re-organizing their curriculum, and as soon as it was ready we would have it.

Continued

The request for information and the recommendation by the Foreman of the Coronary Jury were not related in any way.

(56) The Canadian Memorial Chiropractic

College had requested this Board to obtain certain information relating to a possible faculty appointment. A letter was sent, following a telephone conversation, to the Registrar-Treasurer of The College of Physicians and Surgeons dated October 21st, 1961 stating in part:



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"In respect to our telephone conversation of a week ago, would you be good enough to obtain an opinion or a ruling from your Executive Council with respect to the following -

"Is there any ruling or regulation which would jeopardize or abrogate any of the rights or privileges of a registrant under The College of Physicians and Surgeons of Ontario because the registrant taught or demonstrated in a recognized college of Chiropractic? The subjects under discussion would be the basic subjects of anatomy, pathology, chemistry, et al and would not consist of subject that are singular to the practice of medicine and surgery, such as materia medica and surgery."

(57). The reply of The College of Physicians and Surgeons dated November 2nd, 1961 stated that this communication would be placed before the Executive Committee when it met in January, 1962.

Statement: (pages 10796 - 10797 - 10798)

"... if such requirements are necessary, as is suggested in that recommendation, that the facilities are already in existence where these things and these studies may be carried on by anybody who wishes to go into the field of the healing art, there are medical schools, there are scientific schools in connection with the others, that teach these basic sciences; medical training is not necessarily all received in medical schools ... these facilities are available and it could be set up as a special thing

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college of Chiropractic? The subjects under

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(27).

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connection with the others, that teach these basic

sciences; medical training is not necessarily all

received in medical schools... these facilities are

available and it could be set up as a special thing



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and they are being provided through our educational system ... if an individual wants to practise a particular type of healing art, that having gotten these basic things ... he will ... be able to carry on the healing art more satisfactorily."

Comment:

(58). In essence, this statement suggests that before enrolling in a chiropractic course all students should have previously acquired "adequate" training in the basic sciences at some other institution of higher learning.

(59). The implication is left that chiropractic institutions are unable or incapable of supplying this instruction. It is further implied that this training is available to chiropractic students at other institutions.

(60). The College of Physicians and Surgeons would not appear to be knowledgeable with respect to the training in basic sciences at the Canadian Memorial Chiropractic College in Toronto, as shown by their letter to this Board dated 2nd February, 1962. This letter evades the request for information as to whether a physician would jeopardize his registration by joining the faculty of a chiropractic college, but states as follows:

"After considering your letter of October 31st, 1961, relating to the teaching of certain basic science subjects the College would like to be informed on the following matters:

1. The contents of the entire curriculum in



and they are being provided through our educational system... if an individual wants to practice a particular type of healing art, that having gotten these basic things... he will... be able to carry on the healing art more satisfactorily.

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"After considering your letter of October 2nd, 1961, relating to the teaching of certain basic sciences subjects the College would like to be informed on the following matters:

1. The contents of the entire curriculum in



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the College of Chiropractic.

2. The course content of each subject covered by the curriculum.
3. The number of hours of laboratory and didactic instruction in the Basic Science subjects.
4. The laboratory facilities available for instructional purposes.
5. The facilities for experimental and clinical research.
6. The application of the Basic Sciences taught to the clinical application of Chiropractic.

When you have had an opportunity to prepare this information I would be pleased to receive it, and would then place it before the Executive Committee for their consideration."

(61). In view of this request for information, the Noble Report notwithstanding, it is difficult to understand how a statement such as that made by a representative of The College of Physicians and Surgeons as quoted above could be made to this Commission.

(62). Regulations with respect to chiropractors under The Drugless Practitioners Act require that a candidate for examination and registration shall have graduated from an accredited chiropractic college. For accreditation, such a College must provide adequate instruction and facilities in the basic sciences. Following graduation, this Board is required to examine the candidate, by written examination, in the following



1. The College of Chiropractic.
2. The course content of each subject covered by the curriculum.
3. The number of hours of laboratory and didactic instruction in the basic science subjects.
4. The laboratory facilities available for
5. The facilities for experimental and clinical research.
6. The application of the basic sciences taught to the clinical application of

When you have had an opportunity to prepare this information I would be pleased to receive it, and would then place it before the Executive Committee for their consideration."

(01). In view of this request for information, the Noble Report notwithstanding, it is difficult to understand how a statement such as that made by a representative of the College of Physicians and Surgeons as quoted above could be made to this Commission.

(02). Regulations with respect to chiropractors under The Unlabeled Practitioners Act require that a candidate for examination and registration shall have graduated from an accredited chiropractic college. For accreditation, such a college must provide adequate instruction and facilities in the basic sciences. the candidate, by written examination, in the following



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basic science subjects: - anatomy, histology, physiology, bacteriology, physiological chemistry, hygiene and sanitation, diagnosis and symptomatology, pathology.

Such examination question papers and graded candidates' papers as are on file in the Board office may be examined by the Commission if it so desires.

(63). Following inspection and accreditation of the college and examination of the candidate, this Board feels that suitable standards are maintained.

(64). To the best of this Board's knowledge, instruction in the basic sciences is not available to chiropractic students at other institutions.

Statement: (page 10800)

"... But chiropractors are not restricting themselves to this method of treatment, nor are they capable of investigating illness. Chiropractors are engaged in the practice of medicine poorly trained, without adequate instruction in the basic sciences, without the facilities or the staff to carry this out. Now, if chiropractors would stick to what they are licensed to do there would be no conflict with the medical profession, I feel."

Comment:

(65). Chiropractors by law are not permitted to use drugs, practice surgery or midwifery, and therefore do not practice medicine. They do not come under The Medical Act.

(66). During the past ten years, this Board has not received one complaint from The College of Physicians and Surgeons about a chiropractor practising

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5 medicine. Other than the conviction referred to in
6 paragraph 53, our records indicate that a chiropractor
7 (not now registered to practice in Ontario) was fined
8 \$250 in 1956 for giving a patient sleeping pills.
9 These were prescribed by a physician for the
10 chiropractor's personal use, but he had given some to
11 a patient. A charge of practicing medicine was with-
12 drawn. However, the chiropractor was convicted of
13 selling drugs without a prescription and for employing
14 the title "doctor".

15 (67). Chiropractors are poorly trained to
16 practice "medicine" (i.e. use drugs, practice surgery
17 or midwifery). But it is one of the duties of this
18 Board to ensure that chiropractors are adequately
19 trained to practice chiropractic.

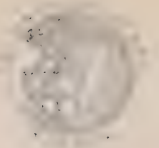
20 (68). Whatever conflict there may be with the
21 medical profession is not the result of the chiro-
22 practor going beyond what he is trained and licensed
23 to do.

24 Statement: (page 10801)

25 "The first requirement, Mr. Chairman, for
26 such a possibility in my opinion would be that any
27 chiropractor, osteopath, any other, would require
28 certain standards of basic sciences, and these would be
29 established, the same ---"

30 Comment:

(69). This statement shows the desire for
initial control of all candidates at the basic science
level. Legislation which would be required for this
type of screening has been enacted in a number of



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Comment:
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jurisdictions on the urging of vested medical interests. The Province of Manitoba and over twenty states in the United States of America have or have had Basic Science Boards. These Boards were created by legislation as being in the public interest, and with the intent of them being an impartial, unbiased and equitable gross screening of all candidates for the healing arts.

(70). However, the deceit in using public interest as a means of accomplishing domination is evidenced by the following:

"The evident original purpose of enacting Basic Science Laws as a prerequisite for licensure in the healing arts was to exclude chiropractors ... from being admitted to licensure. The number of chiropractors appearing before Basic Science Boards is decreasing each year."

(Congress on Medical Education, page 111, J.A.M.A., May 1st, 1948).

(71). Basic Science Boards are not uniform, but vary from jurisdiction to jurisdiction in legislation, number of members, composition of Boards, examination subjects and standards.

(72). To be truly in the public interest, the branch of the healing art or the school of practice of the candidate was intended to be unknown. However, the legislative intent of anonymity has been violated:

"A candidate in applying for a Basic Science certificate is not required by law to mention



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his school of practice. However, by checking the biographic records of physicians and medical student records of the American Medical Association and various directories it has been possible to determine the profession of the majority of candidates."

(J.A.M.A., Vol. 134, No. 3, May 17th, 1947).

(73). To show the extent to which Basic Science laws have been prostituted, the following was revealed before the Supreme Court of the State of Washington:-

"After a full and complete hearing in the Superior Court of Thurston County, the Court found that both respondents (chiropractors Romano and Fleming) had in truth and fact passed the Basic Science examination and each was entitled to a certificate so indicating, and that certain answers on their examination papers which were actually correct, were arbitrarily and capriciously marked incorrect, as was shown when compared with marks given other applicants on similar answers."

"Before passing to a discussion of other examination subjects, we call the court's attention to certain exhibits which fairly reflect the gross favoritism and discrimination shown by the appellant Weiser in the grading of the pathology papers."

"In that part of the examination having to do with the identification of microscopic



his school of practice. However, by checking the diagnostic records of physicians and medical student records of the American Medical Association and various directories it has been possible to determine the profession of the majority of candidates."

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(73)

science laws have been promulgated, the following was presented before the Supreme Court of the State of

"After a full and complete hearing in

the Superior Court of Madison County, the

Rosano and Flinn, had in turn and full passed the basic science examination and each was entitled to a certificate of graduation, and that certain answers on their examination papers which were erroneously corrected, were

arbitrary and capricious and not incorrect, as was shown when compared with marks given

before passing to a discussion or other

examination subject, we call the court's

attention to certain exhibits which fairly

reflect the gross inequities and discrimination shown by the appellant Weiser in the grading

of the pathology papers.

"In last part of the examination having

to do with the identification of microscopic



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slides, which counted as a quarter of the entire examination, we find that some examinees who incorrectly identified every slide were given higher grades on this portion of the examination than examinees who correctly identified some of the slides. ...

"We find the same gross favoritism and discrimination in the grading of the gross specimens portion of the pathology examination.

The Appellant's Evidence

"We think this court must have been astounded to read from the Statement of Facts the nonchalant admissions made by the appellants concerning the marking of the examination papers of the various examinees. The trial court was astonished by the testimony. These admissions demonstrated that the Basic Science Examining Board members seemed to think that they were not obliged to follow the mandate of the statute in the giving of these examinations or in the grading of the papers and that they were entitled to examine concerning advanced subjects as well as elementary subject, and to pass or not to pass applicants as they saw fit, regardless of the applicants knowledge or lack of knowledge.

"The Board passed medical students who presumably have now become practicing physicians and surgeons, and are performing or will perform surgical operations upon human beings



slides, which cannot as a matter of fact
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identified some of the slides.

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The Applicant's evidence

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papers of the various examinees. The trial
court was satisfied by the testimony. These
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Examiners Board members seemed to think that
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were entitled to examine concerning advanced
subjects as well as elementary subject, and
to pass or not to pass applicants as they saw
fit, regardless of the applicant's knowledge or
lack of knowledge.

"The Board passed several students who
practically have not become practicing physi-
cians and surgeons, and are performing or will
perform surgical operations upon human beings



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when their grades in anatomy and pathology in the Basic Science examinations were as low as 39.

"The appellant, Dr. Worcester, Chairman of the Board (and an M.D.), under cross examination admitted that the grades of many of the examinees in the anatomy examination had been raised, some of them as many as three times, in order to give them passing grades on the entire examination. (St. 233-8). He explained this by saying that if it was found that the examinee's grades in the other four subjects would enable him to pass in the entire examination if his grade in anatomy was 70, he then raised the anatomy grade enough to enable the applicant to pass. This explains why examinees who were medical students were permitted to pass this Basic Science examination when their knowledge of anatomy was so meagre as to give them grades as low as 39, when originally and honestly marked. These same medical students, so passed, are now engaged in the practice of Surgery in the State of Washington."

(Remarks taken from Brief pertaining to Cases 28485-28486 of the Superior Court of Thurston County, on appeal to the Supreme Court of the State of Washington in which plaintiffs prevailed.)



readily

when their grades in anatomy and pathology in the basic science examinations were as low

"The appellant, Dr. Worcester, testified

of the Board (and an M.D.), and it comes

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of the examinees in the anatomy examination

had been failed, some of them as many as three

times, in order to give them passing grades

He explained this by saying that it is not

found that the examinees' grades in the other

four subjects would enable him to pass in

the entire examination if his grade in anatomy

was 75, he then set up the anatomy grade

enough to enable the applicant to pass. This

explains why examinees who were medical students

were permitted to pass with basic science

examination when their knowledge of anatomy

was so meagre as to give them grades as low

as 75, when originally and honestly marked,

These same medical students, as passed, are

now engaged in the practice of surgery in the

State of Washington.

(Records taken from brief pertaining to

cases 18455-18465 of the Superior Court

of Thurston County, in appeal to the

Supreme Court of the State of Washington

in which plaintiffs prevailed.)



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(74). In Manitoba, The Basic Sciences Act of 1945 was repealed in 1953 after unfair administration and bias was revealed.

(75). As an alternative to Basic Science laws, a different type of legislation has been designed to provide medical domination of all healing arts branches. This type of control includes uniform medical practice acts, master licensing boards, composite boards and umbrella legislation.

(76). The suggestion to be found on page 10800 as "... the question of overall legislation with one body providing the licensing. ..." appears to indicate a desire to control by this method.

(77). The experience of the chiropractic profession under this type of legislation has been most unfavourable. In Ontario, administration by a mixed drugless board (Board of Regents) until 1952 demonstrated the need for the chiropractic profession to be controlled and administered by its peers.

(78). It can be assumed that the "one body providing the licensing" (as suggested by The College of Physicians and Surgeons) would be composed largely of physicians, and would replace this and similar professional licensing Boards. Under such a proposal, administration of healing arts licensing legislation is committed neither to impartial public officials, nor to one's professional peers. Rather, it would be committed largely to practicing physicians representative of the medical profession, which has a direct financial and professional interest in the suppression

12844 Bailey

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of chiropractors.

(79). The desire of organized medicine to suppress chiropractors was referred to for the year 1923. In the year 1950, another instance of this desire to suppress chiropractors in Ontario was demonstrated by The College of Physicians and Surgeons of Ontario and the Ontario Medical Association (represented by Dr. R. T. Noble). It was the recommendation of these bodies to the Honourable Mr. Justice W. D. Roach, conducting a Royal Commission inquiring into the Workmen's Compensation Act of Ontario, "that the words 'the aid of drugless practitioners registered under The Drugless Practitioners Act' wherever they appear in Section 50 be deleted therefrom."

(80). If this recommendation had been accepted, injured workmen of this Province could not have received chiropractic care as provided for in the Act for accidental injuries sustained at work.

(81). The Honourable Mr. Justice W. D. Roach rejected such a recommendation and commented as follows:-

"The Board is not concerned with any jealousies or conflict in opinion or technique that may exist between physicians and drugless practitioners. The welfare of the injured workman is its main concern. That is why the power is given to the Board to determine the question of the necessity, character and sufficiency of any medical aid furnished or to



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be furnished to the workman."

(page 103, Report on The Workmen's Compensation
Act, May 31, 1950).

Concluding Statements:

(82). Several American reports have been compiled on the chiropractic profession, and it is probable that these have been submitted as factual evidence by medical groups to this Royal Commission. To comment on all the inaccuracies which have to do with the licensing and regulation of chiropractors in these reports would require several hundreds of pages.

(83). However, this Board did not consider it possible in a limited time to undertake such a detailed rebuttal of American writings. These reports are similar in tone, bias and inaccuracy to "The Noble Report", and are therefore not dealt with, for the sake of brevity, in this rebuttal.

(84). The report previously referred to as "The Noble Report" is titled "A Study of Osteopathy and Chiropractic", and was prepared for The College of Physicians and Surgeons of Ontario by Warwick H. Noble, Q.C., dated at Toronto, December 1st, 1958.

(85). Detailed comment is not being made on its over one hundred pages.

(86). A number of points applicable to this Board's responsibilities were taken from this report prepared by Mr. Noble, and incorporated into the written and oral submissions by The College of



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A number of points applicable to this

Board's responsibilities were taken from this report prepared by Mr. Noble, and incorporated into the written and oral submissions by the College of



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Physicians and Surgeons, and have already been answered and briefly commented upon. These various points serve to show the impossibility of the report being regarded as "A factual study". Therefore, it would seem illogical for the Commission to make any final decision or recommendations based on such misinformation as is found in this report. The views of the medical profession, as expressed by its official bodies, on the legislative control and practice of chiropractic in Ontario appear to be based on hearsay and knowledge of dubious accuracy. There is little to indicate that any real effort was made to gather information, chiropractic treatment sought, chiropractic offices or the chiropractic college in Toronto visited, or even conversations held with chiropractors, chiropractic associations or this Board, for "free and full discussions and exchange of information" on which to base opinions.

(87). In conclusion, this Board requests that the Commission, in its deliberations on the vast and far-reaching problem of the provision of health services, give due consideration to the foregoing comments and places those reports critical of the chiropractic profession and its administration in their proper perspective.

(88). The following recommendations appear to fulfill the necessary recognition of the rule of law, the rights of the individual and the protection of the public interest:

(a) that health remain a provincial responsibility,



Physicians and Surgeons, and have already been
answered and briefly commented upon. These various
points serve to show the impossibility of the report
being regarded as "A factual study". Therefore, it
would seem illogical for the Commission to make any
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of the medical profession, as expressed by the
official bodies, on the legislative control and
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on hearsay and knowledge of dubious accuracy. There
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to gather information, chiropractic treatment sought,
chiropractic offices or the chiropractic college in
Toronto visited, or even a consultation held with
chiropractors, chiropractic associations or with
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of information" on which to base opinion.

(87) In conclusion, this Board requests that
the Commission, in its deliberations on the report and
far-reaching powers of the provision of health
services, give due consideration to the foregoing
comments and places these reports critical of the
chiropractic profession and its administration in
their proper perspective.

(88) The following recommendations appear
to fulfill the necessary recognition of the role of
law, the rights of the individual and the protection
of the public interest:
(a) that there remain a provincial responsibility



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at present.

(b). that in view of the history of medical attempts to eradicate, dominate or eliminate chiropractic, separate legislation by way of a Chiropractic Act be recommended by the Commission for enactment in Ontario. This legislation should:

(1) be based on the experience of this Board and the profession it controls, and thus recognize those recommendations made in 1957.

(2) include provision for complete control of registrants practicing as chiropractors (see paragraph 41)

(3) take into account the view generally held by the profession in Ontario that discrimination exists in the provisions of Section 53 of The Medical Act with respect to the use of the title "Doctor", and that chiropractors should be permitted use of the title providing it is qualified the same as for dentists.

(c) that the present legislative system wherein a Board composed of chiropractors, charged with administration of the Act and responsible to the Minister of Health, be continued.

(89). We wish at this time to thank the

Commission for the opportunity of commenting on

statements made in previous submissions. We would be pleased to supply to the Commission whatever other information is necessary or helpful and which can be supplied by this Board.



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that in view of the history of medical attempts to eradicate, dominate or eliminate chiropractic, separate legislation by way of a Chiropractic Act be recommended by the Commission for enactment in Ontario. This legislation should:

- (1) be based on the experience of other jurisdictions and the profession in Ontario, and

made in 1955.

- (2) include provision for complete control of registrants practicing as chiropractors

and (see paragraph 41)

- (3) take into account the view generally held by the profession in Ontario that discrimination exists in the provisions of Section 55 of the Medical Act with respect to the use of the title "doctor", and that chiropractors should be

- permitted use of the title providing it is clarified the same as for dentists. (c) that the present legislative system wherein a Board composed of chiropractors, charged with administration of the Act and response to the Minister of Health, be continued.

We wish at this time to thank the

(85)

Commission for the opportunity of commenting on

statements made in previous submissions. We would be pleased to supply to the Commission whenever other information is necessary or helpful and which can be supplied by this report.



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APPENDIX 2

ANNUAL REPORT

College of Physicians and Surgeons of Ontario.

April 1958 - April 1959.

OSTEOPATHS AND CHIROPRACTORS

It is no secret that both the Osteopaths and Chiropractors were seeking new legislation to increase their present rights, privileges, and powers with respect to the art of healing at the last session of the Legislature. Nothing happened, but we may rest assured that they will continue to press for enlargement of their present legal rights. Members of the Council are fully aware of these activities and will do all in their power to see that all those persons or groups of persons who in any way practise the art of healing have attained a certain minimum standard of education, especially in the Basic Sciences, before they are allowed any extension of their existing privileges with respect to the healing arts.

An exhaustive study assembling all available information has been made by The College solicitor and copies have been distributed to those most directly concerned.

It is interesting to note that in the first Medical Act for Ontario the Council of the College had five representatives from the Homeopaths then in Ontario, and also five representatives from the Eclectics. We are facing a similar situation today with respect to



ANNUAL REPORT

College of Physicians and Surgeons of Ontario

April 1938 - April 1939

COURT CASES AND CHIROPRACTORS

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We are facing a similar situation today with respect to



Beasley

12850

Osteopaths and Chiropractors and others registered under the Drugless Practitioners Act. Can all these practitioners with limited qualifications be brought under the jurisdiction of The College, and if so, what concessions are we willing to make, and what requirements must be met by them in order to accomplish what seems desirable, namely; control of all those who by any known means practise the art of healing.

Discussions have already begun with one of these bodies and such, no doubt, will take place in the future with other bodies practising the healing art. Ultimate success can only be attained by free and full discussion, and exchange of information, compromise and concessions on the part of all those who are truly concerned with ensuring the highest standard of medical care for the residents of this Province. There is a long road to travel before we reach this goal.

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1914

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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Beasley 12851

---EXHIBIT No. R-3: Submission of the
Board of Directors
of Chiropractic

SUBMISSION OF THE BOARD OF DIRECTORS
OF CHIROPRACTIC

Appearances: Dr. Harold Beasley - Chairman of
the Board
Dr. S. F. Sommacal - Vice-Chairman
of the Board
Dr. J. W. Ellison - Secretary-
Treasurer of
the Board
Dr. C. A. Greenshields -
St. Catharines

DR. BEASLEY: Mr. Chairman, members
of the Commission, we appear before you representing
the government-appointed licensing Board for chiro-
practors in the Province of Ontario, officially named the
"Board of Directors of Chiropractic".

My name is Harold Beasley, and my
official capacity is Chairman of the Board. May I intro-
duce my associates, Dr. S. F. Sommacal, who has practised
chiropractic for over fifty years, of Toronto, Vice-
Chairman of the Board, Dr. J. W. Ellison of Toronto,
Secretary-Treasurer of the Board, and Dr. C. A. Green-
shields of St. Catharines, Ontario.

Thanks

May we express to you at this time, the
appreciation of the Board of Directors of Chiropractic



Beasley 12852

for the opportunity of submitting facts and comments in rebuttal to previous submission.

Reason no previous submission

There did not appear to be any necessity for a previous submission, since the brief presented in May, 1962 by the Ontario Chiropractic Association summarized Ontario chiropractic legislation and administration.

Reason for rebuttal submission

This rebuttal submission is intended to answer certain factual inaccuracies, distorted implications or conclusions, and charges of incompetency made to this Royal Commission concerning matters within the purview of this Board.

General abstract of rebuttal:-

Some of the salient conclusions may be stated concisely as follows:-

(1) that chiropractors are the most competent to administer the legislation affecting their own profession. Experience in Ontario and in other jurisdictions has amply demonstrated this to be the case.

(2) that this Board has acted with competence in fulfilling all of its obligations. Any areas of deficiency have been shown to be the result of opposition and delaying tactics to requests for adequate authority.

(3) that educational standards currently required by law are adequate, but are under constant study and review.



for the opportunity of submitting facts and comments in
rebuttal to previous submission

Reason for previous submission

There did not appear to be any necessity
for a previous submission, since the brief presented in
May, 1962 by the Ontario Chiropractic Association sum-
marized Ontario chiropractic legislation and the situation.

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General Abstract of Rebuttal

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tions has amply demonstrated this to be the case.
(2) that this Board has acted with competence
in fulfilling all of its obligations. Any areas of
deficiency have been shown to be the result of opposition
and delaying tactics to requests for adequate authority,
(3) that educational standards currently
required by law are adequate, but are under constant



Beasley 12853

(4) ~~graph~~ evidence has been submitted to show clearly that the objective of the medical profession, by supplanting chiropractic boards, is to eventually eliminate chiropractors, rather than to protect the public interest.

(5) ~~for~~ regulation and control of health practitioners is the responsibility of Government -- and this responsibility cannot be effectively and efficiently delegated exclusively to any one group in the healing field.

(6) identical training for all healing arts practitioners has been shown to be unreasonable and unnecessary. It is one of the duties of this Board to ensure that chiropractors are adequately trained to practice chiropractic.

(7) it is anticipated that the studies and recommendations of this Royal Commission will be factual, practical and in sufficient depth. Such findings will undoubtedly show that the suggested "further studies" as recommended by the College of Physicians and Surgeons would be needless repetition and a waste of public funds for ulterior motives.

(8) the various types of administrative Boards and their effect have been noted briefly.

(9) the intent of, and experience with, various Basic Science Boards supposedly established for gross screening has been shown to be prejudiced, discriminatory and even dishonest.

Recommendations:-

The brief concludes with the following



(4) Evidence has been submitted to show clearly that the objective of the medical profession, by supplanting chiropractic boards, is to eventually eliminate chiropractors, rather than to protect the public interest.

(5) Regulation and control of health practitioners is the responsibility of Government - and this responsibility cannot be effectively and efficiently delegated exclusively to any one group in the healing field.

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(8) The various types of administrative boards and their effect have been noted briefly. (9) The intent of, and experience with,

Gross screening has been shown to be prejudiced, discriminatory and even dishonest.

The brief concludes with the following



Beasley 12854

paragraph -

"The following recommendations appear to fulfill the necessary recognition of the rule of law, the rights of the individual and the protection of the public interest:-

- (a) that health remain a provincial responsibility, as at present.
- (b) that in view of the history of medical attempts to eradicate, dominate or eliminate chiropractic, separate legislation by way of a Chiropractic Act be recommended by the Commission for enactment in Ontario. This legislation should:-
 - (1). be based on the experience of this Board and the profession it controls, and thus recognize those recommendations made in 1957.
 - (2). include provisions for complete control of registrants practicing as chiropractors (see paragraph 41) of our rebuttal submission.
 - (3). take into account the view generally held by the profession in Ontario that discrimination exists in the provisions of Section 53 of The Medical Act with respect to the use of the title "Doctor", and that chiropractors should be permitted use of the title providing it is qualified the same as for



Beasley 12855

dentists.

(c) that the present legislative system wherein a Board composed of chiropractors, charged with administration of the Act and responsible to the Minister of Health, be continued."

Conclusion:-

This concludes our oral summary, thank you.

I would like to add that had certain submissions not been made to this Commission, this brief would not have been necessary. We regret that it has to be done.

THE CHAIRMAN: Thank you Dr. Beasley. Much of the ground which you cover here is covered in the previous submission. As you appreciate, that obviates the necessity of going over the same ground again.

Have you anything additional to add in connection with this idea that I put forward about the chiropractic becoming more integrated with medicine and being one of the specialties of medicine?

DR. SOMMACAL: The great difficulty there is to maintain its separate identity.

THE CHAIRMAN: That is the very thing I wanted to put to you: Is not this a matter of identity status.

DR. SOMMACAL: Not status so much as practice.



General.

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CHAIRMAN

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THE CHAIRMAN: Thank you Dr. Bessley.

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DR. BESSLEY: Yes, I do.

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THE CHAIRMAN: That is the very thing
I wanted to put to you. Is not this a matter of

DR. SOMMAGAL: Not at all so much



Beasley 12856

THE CHAIRMAN: Assuming that, as a specialty, the chiropractor would be well trained to carry out his specialty and therefore how he did it would rest in his own hands. Is it necessary that you remain a chiropractor in order to practice what you say are the basic principles of chiropractic?

DR. SOMMACAL: I think perhaps you have an example with homeopaths in Ontario who, when they were absorbed or recognized by the allopathic profession were made to adopt the allopathic study, or study allopathic medicine and this practically eliminated homeopaths.

They could not, or they did not pursue the homeopathic medicine as well as the allopathic medicine. Quite a few have done that. Very few. It was necessary for them to study allopathic medicine and they did supplement that with homeopathic study. Once they studied allopathic medicine, they pursued that form of practice.

I would imagine that would happen with chiropractic if medical were included in his studies.

THE CHAIRMAN: Well, are you saying that you could not survive the competition and the same discipline?

DR. SOMMACAL: Knowing human nature as we do - chiropractic entails a good deal of effort, physical effort, not that it is strenuous but it is a departure entirely from the practice of medicine, and it is much simpler to apply a remedy than it is to apply a treatment, and knowing human nature as



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Beasley 12857

we do, the natural tendency is to apply a remedy rather than a treatment, especially when you get older.

THE CHAIRMAN: Is there anything you wish to add? I might say your answer disconcerts me somewhat.

DR. SOMMACAL: Perhaps I do not grasp the significance of the question you asked me.

THE CHAIRMAN: Provided the climate was right, the chiropractor could be educated in the proper co-operative climate and imbued with all the enthusiasm or dedication that he may have now to heal by the chiropractic process. Now, would he necessarily lose that by being trained along with the other health personnel? Because there is so much in common; you are all telling us that the basic sciences are the same, that a great part of your curriculum is the same, and you only part up at the top. Now, are you going to forget all the chiropractic principles if you are taught medicine as well?

DR. SOMMACAL: I do not think the present chiropractor would. I do not know anything about the future.

DR. ELLISON: Could I speak to that, Mr. Chairman?

THE CHAIRMAN: Yes.

DR. ELLISON: The assumption that the chiropractic would be lost is not true if the education was such that the chiropractic is taught to the student by somebody who understood chiropractic; but if they were taught in all their college years by somebody who



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Ellison 12858

came through medical school with the assumptions of medicine, then I would think that the chiropractic at that stage would not be as good as the chiropractic you are getting now.

DR. GREENSHIELDS: Mr. Chairman, I think your suggestion is an excellent one, but it appears to be rather idealistic in view of the way things are at the present time. It boils down to the intent and purpose of all concerned, and, as you put it, we do not feel the climate is such at the present time that that can be achieved, although it is certainly possible in the future, and perhaps this Commission will be the start of some steps in that direction.

THE CHAIRMAN: I mean to say, can we not be idealistic rather than seeing true sections of the healing arts slugging at each other the way they are going at it now?

DR. BEASLEY: I must say, Mr. Chairman, that we did not start this offensive.

THE CHAIRMAN: Yes, but you have to start slugging back.

DR. ELLISON: The basic sciences as a whole have not been effective.

COMMISSIONER BALTZAN: Is there not more than one basic science? If there is basic science, it is basic for one thing, that and the other. Can basic science be built into that which the Chairman has pointed out?

DR. GREENSHIELDS: Up to now the basic science has differed: reciprocity, and so on, the Board



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Greenshields 12859

of Examiners, and also the number of subjects and also in grading procedures.

COMMISSIONER BALTZAN: There is nothing wrong with basic science element of it; it is the people who try to judge it or interpret it. That is where the quarrel is.

DR. ELLISON: That is right.

DR. GREENSHIELDS: We may compare our position with that of the struggle of dentistry to be part of the healing art. Our position does parallel that, and all the medical profession saw was that there was a service rendered that the physician himself was not trained to do, and therefore once it became established, co-operation became impossible.

THE CHAIRMAN: Was the area easily definable in dentistry?

DR. GREENSHIELDS: Yes. Dentistry is involved in teeth and gums, and now we get into tempero mandibular complaints of the gums. Our area involves all areas of the body.

THE CHAIRMAN: We are told the dentists want more colleges, the doctors want more colleges, and so on, and yet up to a certain area, through the basic science area in all its concepts, you all cover the same ground but you do want to do it independently. Why cannot we take you up to a point and then only fragment you out into a specialty?

DR. SOMMACAL: I think there was an effort to see that basic science could be taught, and our Dr. Smith seemed quite agreeable to a suggestion.



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Sommacal 12860

It was later turned down. We do not know why.

THE CHAIRMAN: Well, we are grateful to you, gentlemen, for bringing your problem to us. These are things we have to face up to, and the more enlightenment we can have on them we hope will be all to the good. Thank you very much.

DR. BEASLEY: Sir, on behalf of our Board, thank you very much.

THE CHAIRMAN: We will recess until quarter-past-two.

---LUNCHEON RECESS



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We will release until

quarter past two.



Stewart

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---UPON RESUMING AT 2:15 p. m.

THE SECRETARY: Mr. Chairman, the next submission is a private brief by Miss Grace Stewart to be known as R-4, and the additional Exhibits which she has filed, containing Exhibits 1 to 5, will be known as R-4A.

---EXHIBIT No. R-4: Private Brief by
Miss Grace Stewart

---EXHIBIT No. R-4A: Exhibits 1 to 5.

SUBMISSION OF PRIVATE BRIEF

BY MISS GRACE STEWART

Appearances: Miss Grace Stewart



Stewart

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R-4A.

EXHIBIT No. R-4 Private Brief by

SUBMISSION OF PRIVATE BRIEF

BY MISS GRACE STEWART

Appearances: Miss Grace Stewart



Stewart

12862

SUMMARY

MISS STEWART: Mr. Chairman and the members of the Royal Commission on Health Services, I am pleased to have the opportunity to present this supplementary and rebuttal brief.

It is important that recommendations that have been made to this Commission and which appear to be sound but are not sound - be challenged.

There is a threat to democracy, to our way of life and to individual freedom today. It is not a danger, like war, that we can battle face to face. It is an unrecognized danger, because it wears a cloak of democracy.

Measures that are dictatorial and alien to our constitution, are today proposed and propounded as the right of every citizen in a Democracy. The serfdom of the Welfare State has become the right to have a roof over our heads, the right to have enough to eat and drink; because the proposals sound plausible and have a degree of similarity to some phase of existing legislation, or rights, they are not recognized. Democracy has become the wedge to open the door to a Welfare State.

It is my duty and my privilege to challenge and rebut the arguments put forward for a Compulsory Nation-Wide Medical Insurance Plan, and for Fluoridation of Public Water Supplies, the chief proponents of which are respectively, the Government of Saskatchewan, the Saskatchewan Federation of Labor and the Edmonton Fluoridation Council and the Canadian Dental Association. I do rebut these arguments on the grounds that the

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Stewart

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proposals are not democratic, are not consistent with the regulations as set out by this Commission, are not based on fact, convey a wrong impression and by so doing have nullified the argument, the statements and the recommendations made by myself in a brief to this Commission.

Position

1. The position taken by the proponents of a Compulsory Nation-Wide Medical Insurance Plan, can be summarized as follows:-

(a) That: the need for health services is universal.

(b) That: the complex problems of health and disease can be solved best by governments at all levels, organizing, planning and financing basic health services as public services.

(c) That: one of the major problems is the delineation of the state of health of the citizens (whether the individual is in a state of illness, sub-health or an ideal state of healthiness) and that an attempt be made to measure health on this basis.

2. The nature of this approach is contrary to our Constitution, and is not consistent with the regulations as set out by this Commission, under P.C. 1961 - 883, on the following grounds:-

1. It is not Democratic in that:

(a) it seeks to change the structure of our Constitution by making personal



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Stewart

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health services, public services, and

(b) in so doing is contrary to the

British North America Act, Section 91

and Section 92, under which the powers

of Parliament and the powers of the

Provincial Legislatures are defined.

(c) it is contrary to the Canadian

Bill of Rights, Bill C79, paragraph 2,

clause (a).

2. It is not consistent with the regula-

tions as set out by this Commission,

under P.C. 1961 - 883 -

(a) to recommend such measures consis-

tent with the constitutional division

of legislative powers of Canada.

3. On the count of "not Democratic"

I would refer to Foreword of the British North America

Act, page 111, paragraph (2).

"In preparing this consolidation an

attempt has been made to reflect

accurately the substance of the law

contained in the series of enactments

known as the British North America

Acts, and other enactments modifying

the provisions of the original British

North America Act, 1867."

4. John Locke, a philosopher of the

16th and the 17th centuries, in his essay, on "Civil

Government", became the formulator of constitutional law

and democratic processes as we know them today. The ends



Stewart

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Stewart

12865

of political society and government, as defined by John Locke, page 129, paragraph 124 are, "the great and chief end, therefore, of men's uniting into commonwealths and putting themselves under government, is the preservation of their property." (In the previous paragraph John Locke explained that he called lives, liberty and property by the general name of property) to which in the state of nature there were many things wanting.

5. Section 91 and Section 92 of the British North America Act, reflect the viewpoint endorsed by this great philosopher, in that "the powers of parliament and of the provincial legislatures refer to those measures of a public nature only."

6. It is a reasonable assumption then, that: "the attempt through recommendations to this commission, to have personal health services made public services, must be construed as being contrary to our democratic way of life", to our Canadian Bill of Rights, and to the purpose of this Commission.

Problem

7. The problem, as identified by the Government of Saskatchewan and the Saskatchewan Federation of Labor, is:-

That: the need for health services is universal.

8. I suggest that "the problem as so defined is not relevant to the issue under study, in that the said problem exists only from a philosophical point of view."

9. The Government of Saskatchewan (on

of political society and government, as defined by John

and, therefore, of men's living in commonwealths and

of their property." (In the previous paragraph John

Locke explained that he called this, liberty and

property by the general name of property) to which in the

state of nature there were many things wanting.

2. Section 91 and Section 92 of the

British North America Act, reflect the viewpoint endorsed

by this great philosopher, in that the powers of legisla-

ment and of the provincial legislatures refer to those

measures of a public nature only.

that: "the attempt through recommendations to this commis-

sion, to have personal health services made public ser-

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defined is not relevant to the issue under study, in that

the said problem exists only from a philosophical point

9. The Government of Saskatchewan (on



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page 11, paragraph 31, Government brief) supported its viewpoint with the following argument:-

"The most significant characteristic of health services is that the need for them is universal. While some of us may be so fortunate as to avoid serious illness or injury all of us have aberrations, however minor, from a state of maximum healthiness. While most persons in a community have only relatively small needs for definite services for themselves, all persons in a community require services of which they may be unaware. We refer here specifically to those health services which protect our water supplies, which oversee the safe disposal of wastes, which isolate hazards and in general assure a safe environment."

10. I do further suggest "that the aforementioned argument is not sound on the following grounds":-

1. The comparison is not true, in that one type of service is personal health services, and the other is public health services.

To further support my argument, I would make the following comparison:-

"To state that because all citizens use public services such as water supplies, the safe disposal of wastes, etc., the



page 11, paragraph 51, Government brief) supported its viewpoint with the following argument:

"The most significant characteristic of health services is that the need for them is universal. While some of us may be so fortunate as to avoid serious illness or injury all of us have about rations, however minor, from a state of maximum healthiness. While most persons

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water supplies, which oversee the safe disposal of wastes, which isolate hazards and in general assure a safe environment. I do further suggest that the

forementioned argument is not sound on the following

grounds:

one type of service is personal health services, and the other is public health services.

To further support my argument, I would make the following comparison:

public services such as water supplies, the safe disposal of wastes, etc., the



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need for personal health services is universal, is the same as:-
to declare that because all citizens use the city bus service or the street sidewalks, the need for cars for all citizens or walks in their backyard is universal."

Approach to the problem

11. The Government of Saskatchewan has, in its approach to the problem, posed two basic assumptions for consideration of this Commission (page 11, paragraph 29, Government brief):-

(a) Society as a whole has a concern about the state of health and disease of its members and each of its members should have equal access to basic and necessary services to maintain health and to remedy aberrations from a state of health.

(b) Each member of society has a responsibility to contribute towards the provision of these services in a manner consistent with his ability to contribute.

12. I DO MOST STRONGLY REBUT THE VIEW-POINT ENDORSED IN THE AFOREMENTIONED RECOMMENDATIONS. I base my argument on the following ground:-

(a) The assumptions posed for consideration are not of a Democratic nature, but are for a planned society.

13. The picture envisioned here is not



for personal health services is

universal, as the same as

to declare that because all citizens

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(b) Each member of society has a responsibility to contribute towards the provision of these services in a manner consistent with his ability to contribute.

POINT ENDORSED IN THE AFOREMENTIONED RECOMMENDATIONS

base my argument on the following grounds:-

(a) The assumptions posed for consideration are not of a Democratic nature, but are for a planned society.
15. The picture envisioned here is not



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one of individuals using their faculties of judgment, foresight, decision and choice to build their lives on a plan that suits their particular character, and in so doing, help to build a better nation. It is NOT a picture of individuals aspiring to different heights by their own efforts, or of being content to remain at a lesser level, but free to choose that which suits them best, and where all have equal opportunity and access to public services.

14. IT IS A PICTURE OF LEVELLED-OUT SOCIETY, where those who have by extra effort and ability, become self-responsible, are compelled to go back to the level of the man who has not become self-responsible. IT IS NOT a question of accepting a responsibility towards the needy (as all citizens already do by way of taxes) to assist those in need and to help them to rise to a better standard. It is a question of PENALIZING THE SELF-RESPONSIBLE BY COMPELLING THEM TO GIVE UP THE PLAN THEY HAVE CHOSEN AND ENCOURAGING (by directing assistance to everyone) irresponsibility, by setting the scale of the nation at this level, and this poses a question:-

"Are we a nation aspiring to greatness through the greatness of each individual?
or -

Are we a nation content to have a standard society, where the individuals are units, all operating in the same way, under a plan, deemed by the government to be what is best for them?

15. Democracy is founded on the

one of individuals using their faculties of judgment, foresight, decision and choice to build their lives on a plan that suits their particular character, and in so doing, help to build a better nation. It is NOT a picture of individuals aspiring to different heights by their own efforts, or of being content to remain at a lesser level, but free to choose that which suits them best, and where all have equal opportunity and access to public services.

14. IT IS A PICTURE OF LEARNED-OUT

SOCIETY, where those who have by extra effort and ability become self-responsible, are compelled to go back to the level of the man who has not become self-responsible. IT IS NOT a question of accepting a responsibility towards the needy (as all citizens already do by way of taxes) to assist those in need and to help them to rise to a better standard. It is a question of REWARDING THE SELF-RESPONSIBLE BY COMPELLING THEM TO GIVE UP THE PLAN THEY HAVE CHOSEN AND ENCOURAGING (by directing assistance to everyone) irresponsibility, by setting the scale of the nation at this level, and this poses a question:-

"Are we a nation aspiring to greatness through the greatness of each individual?

or

Are we a nation content to have a standard society, where the individuals are units, all operating in the same way, under a plan, deemed by the government

to be what is best for them?

15. Democracy is founded on the



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principles of liberty and justice as endorsed by the great philosophers. It would seem to me to be appropriate to quote here, the philosophy endorsed by John Stuart Mills, a philosopher of the 18th century in his essay, "On Liberty", pages 147 and 148:-

"The only freedom that deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it. Each is the proper guardian of his own health whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves than by compelling them to live as seems good to the rest."

16. If we accept the theory that the state of illness or well-being of each individual is a matter of concern to the community or to the nation, we must also endorse the principle of paternal control over the individual by the state, to plan that which the state deems to be good for him.

17. Under Democracy, the government has a RESPONSIBILITY, but NOT a concern. It has a duty, as the servant of the people, to provide a safe setting for the individual to exercise his privilege and accept his responsibility to maintain his own good health. It can be summarized as follows:-

- (a) Control of infectious diseases.
- (b) Provision of a safe water supply.



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- (a) Control of infectious diseases.
- (b) Provision of a safe water supply.



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(c) Sanitation.

(d) Laws to ensure purity of food
and safety and effectiveness of drugs.

(e) Radiation control and protection.

18. It is further argued by the Govern-
ment of Saskatchewan, page 10, paragraph 27 (Government
brief):-

"We believe that each and every indivi-
dual in the state has a right to neces-
sary health services. In our view, we
suggest that this right cannot be
viewed as differing from his right to
a basic education, a basic subsistence
level of food and shelter, protection
of himself and his property from molesta-
tion or to protection from invasion by
foreign intervention."

20. I challenge and rebut this argument
on two grounds:-

(1) It is not based on fact and does
convey a wrong impression.

(2) It is not consistent in that
measures of three different status, a
law, a qualified privilege, and a basic
right, are held up as one comparison.

In the first instance the right to health services is
compared to the right to a basic
education, but -
to obtain a basic education is a
law which we must obey.



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(e) Radiation control and protection.

and safety and effectiveness of drugs.

(d) Laws to ensure purity of food



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In the second instance the right to health services is compared to the right to a basic subsistence level of food and shelter, and - the right to a basic subsistence level of food and shelter is a qualified privilege under the right to assistance in time of need.

In the third instance, the right to health services is compared to the right to protection of himself and his property from molestation and to protection from foreign intervention, but - the right to protection of himself and his property from molestation and to protection from foreign intervention is a basic right.

21. The right to health services is a qualified privilege under the right to assistance in time of need."

22. I contend that, in making the comparison in the second instance, the Government of Saskatchewan has, unintentionally, shown in what category the right to health services belongs (as a qualified privilege) this being the only true comparison and I further content that, in so doing, the said government has made its argument that "health services are a basic right", void.

In the second instance the right to health services is compared to the right to a basic subsistence level of food and shelter, and the right to a basic subsistence level of food and shelter as a qualified privilege under the right to assistance in time of need.

In the third instance, the right to health services is compared to the right to protection of himself and his property from molestation and to protection from the right to protection of himself and his property from molestation and to protection from foreign intervention as a basic right.

21. The right to health services is the qualified privilege under the right to assistance in time of need.

comparison in the second instance, the Government of the right to health services belongs (as a qualified privilege) this being the only true comparison and I further content that, in so doing, the said Government has made its argument that "health services are a basic right", void.



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23. Recommendations. As a solution to the problem, the Government of Saskatchewan has recommended several remedies, which it has termed "complementary" remedies (page 15, paragraph 38, Government brief); they are as follows:-

(a) A planned approach to large-scale organization of health care services to achieve a more efficient distribution and use.

(b) A stable flexible and equitable system of meeting expenditures involved in providing health services.

(c) A means to allocate responsibilities in the health field between the citizen as patient and taxpayer, all levels of government, the voluntary health agencies and the various professions involved in providing health care.

24. I DO MOST STRONGLY OPPOSE AND REBUT THESE RECOMMENDATIONS on the following grounds:-

1. The nature of the aforementioned remedies is not complementary, it is alien.

2. The measures seek, by planned large-scale organization, to destroy the structure of twin pedestals in our society and erect one pedestal - the State.

3. The intent of (sub-paragraph (c), page 15, Government brief) is not to



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allocate responsibilities but to
RE-ALLOCATE responsibilities according
to the viewpoint endorsed by the
Government of Saskatchewan.

25. It is further argued by the Govern-
ment of Saskatchewan that "our economic system as it
operates in the field of personal health is failing to
achieve the proper distribution of services to indivi-
duals, which it is their right to expect."

26. I have sought to prove in my argu-
ment on page 4 and page 5 of this brief, that: "the right
to health services is a qualified privilege under the
right to assistance in time of need."

27. It is in the field of public health
and of need of assistance then, that the statement made
by the government and as set out in paragraph 25 must be
argued. On page 4, paragraph 17, I have outlined the
responsibilities of government in relation to public health
services; while I have not, perhaps, listed all of the
measures, I have set out the major ones.

28. In the field of personal health the
Federal Government has assumed some responsibility for
certain measures which by reason of a certain characteri-
stic are of a character that places them beyond the realm
of ordinary health and into a special category. I would
refer here to such diseases as Cancer and Tuberculosis,
that require much research and cause death, and to Blind-
ness and Disability.

29. In all of these measures is embodied
a basic principle, assistance in measures of a special



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category, applied in such a way that as soon as the need does not exist, the assistance can be withdrawn. These are complementary measures.

30. A review of health services in Canada, as contained in a report by J. Waldo Monteith, Minister of National Health and Welfare, The Financial Post of June 11, 1960, revealed the following facts:-

"Standing at 7.9 per 1,000 population in 1958, our crude death rate was not only the lowest in history but also the second lowest of any major country in the world.

Infectious diseases, which in 1926 accounted for 13 percent of all deaths, now cause less than 2 percent.

Since World War II, deaths from Tuberculosis have been reduced to one-eighth their former level."

31. In the economic picture, while we have had rising costs, we have also had higher wages, and the picture is NOT one of inability to purchase services but of a HIGHER standard of living and more purchasing power. It was estimated that Canadians spent some \$60,000,000 on toys in 1961 and \$5,000,000 on Valentine cards in 1962.

32. At the end of 1960 more than half the population of Canada was covered by some form of Voluntary Health Insurance, as indicated by the results of the 1960 survey of Voluntary Health Insurance in Canada, released on January 12th, 1962, by the Canadian Conference

category, applied in such a way that as soon as the need does not exist, the assistance can be withdrawn. These are complementary measures.

30. A review of health services in Canada, as contained in a report of J. Valdebonnet, Minister of National Health and Welfare, The Financial Post of June 11, 1960, revealed the following facts. "Regarding the 1958-59 population in 1958, our crude death rate was not only the lowest in history but also the second lowest of any nation recorded in the world."

Infectious diseases, which in 1958 accounted for 11 percent of all deaths, now cause less than 2 percent. Since World War II, Canada has tuberculosis. Deaths have been reduced to one-eighth their former level.

31. In the economic sphere, while we have had rising costs, we have also had rising wages, and the picture is not one of inflationary pressures. Services at a high standard of living and more purchasing power. It was estimated that Canadians spent some \$6,000,000,000 more in 1959 than \$5,000,000,000 in 1952. Line cards in 1960.

32. At the end of 1959 more than half the population of Canada was covered by some form of Voluntary Health Insurance, as indicated by the results of the 1960 survey of Voluntary Health Insurance in Canada. January 15th, 1962, by the Canadian Conference



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on Health Care.

33. The survey revealed that more than 52 percent of the population have voluntary coverage for surgical expenses, as compared with 20 percent with similar coverage at the end of 1950 and that some 48 percent or 8,600,000 Canadians have voluntary coverage for medical expenses as compared with 12 percent of the population, with similar coverage ten years ago.

34. These figures reveal an increase in the number of people enrolling in Voluntary Medical Plans, that has steadily increased during a ten-year period.

35. The figures obtained from Group Medical Services over a period of thirteen years reveal the following changes in their premium rates: single person (group plan) in 1949, \$1.50; in 1962, \$2.75; a couple in 1949, \$3.00 and in 1962, \$6.00 and for a family in 1949, \$3.50 and in 1962, \$7.00. There has been no increase for five years. While there have been slight increases in some groups these figures convey a general picture.

36. On the other hand the cost of the Compulsory Government-operated National Health Plan in Great Britain has increased some 600 percent since it was set up in 1947.

37. In 1938 the cost was estimated in the Beveridge Report (known as the White Paper) at £70,000,000 -

When the Labor Government gained power in 1940, it



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was revised to - £ 170,000,000

In 1959 the plan cost - £ 775,000,000

The 1962 estimate is - £1,000,000,000

38. These figures do not support the viewpoint that all levels of government can best solve the problems of health by planning, organizing and financing personal health services as public services.

39. A review of the picture of health services as they exist in Canada today brings to the fore two important factors:-

(1) That: the majority of the citizens of Canada are self-responsible and are taking care of their own personal health needs.

(2) That: in the field of public health great progress has been made.

40. The factor of need for health services, as it exists (a factor which has been ignored by the Government of Saskatchewan and the Saskatchewan Federation of Labor) is "for a minority group only."

41. The problem, then, is NOT a universal need that requires large-scale overall organization, BUT is the need for assistance to a minority group, the aged and those who are in need of assistance because of circumstances.

Conclusion

I have attempted to show by factual reference that the recommendations and some of the statements made in the briefs submitted by the Government of Saskatchewan and the Saskatchewan Federation of Labor are



was revised to \$ 170,000,000
In 1959 the plan cost - \$ 725,000,000
The 1962 estimate is \$1,400,000,000

38. These figures do not support the viewpoint that all levels of government can best solve the problems of health by planning, organizing and financing personal health services as unified services.

39. A review of the picture of health services as they exist in Canada today points to the following two important factors:-

(1) That the majority of the citizens of Canada are self responsible and are taking care of their own

(2) That in the field of public health great progress has been made. The factor of need for health

services, as it exists (a factor which has been ignored by the Government of Saskatchewan and the Saskatchewan Federation of Labor) is "for a minority group only".

40. The problem, then, is not a matter of need that requires large scale social organization, but is the need for assistance to a minority group, the aged and those who are in need of assistance because of

Conclusion

reference that the recommendations and some of the comments made in the briefs submitted by the Government of Saskatchewan and the Saskatchewan Federation of Labor are



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not Democratic and are not based on fact.

I do most strongly urge that this Commission, in its study of the recommendations in the aforementioned briefs, study the nature of the proposals contained therein and the implications of the said recommendations on the individual and on the nation.

I would draw attention to the danger of accepting, even in one field of the economy, the principle of a planned approach and the resultant danger that this structure would become a base for other measures of a similar nature.

I would urge that serious consideration be given to the plan which I recommended in my original brief and to those recommendations in other submissions for similar plans which are designed to assist those in need but at the same time recognize the principles of freedom and responsibility.

Respectfully submitted - Grace Stewart.

Second Section

SUPPLEMENTARY AND REBUTTAL BRIEF

Mr. Chairman and the members of this Royal Commission:

1. The second section of my brief is in rebuttal against the recommendations for fluoridation of public water supplies, the chief proponents of which are the Edmonton Fluoridation Council and the Canadian Dental Association.

2. I do challenge and rebut the arguments and the recommendations of the said Council and the said Association on the grounds that they are an



not Domestic and are not based on facts

I do most strongly urge that this Committee

in its study of the recommendations in the above

mentioned briefs, study the nature of the proposals

contained therein and the implications of the said

recommendations on the industry and on the nation.

I would draw attention to the danger of

accepting, even in one field or the other, a principle

of a planned approach and the resultant danger that this

structure would become a barrier to other measures of a

similar nature.

I would urge that serious consideration

be given to the plan which is recommended in the original

brief and to those recommendations in other submissions

for similar plans which are designed to assist those in

need but at the same time recognize the prime place of

freedom and responsibility.

SUPPLEMENTARY AND EXPLANATORY

Mr. Chairman and the members of this

1. The second section of my brief is in

rebuttal against the recommendations for fluctuation of

public water supplies, the chief proponents of which are

the Edmonton Water Board and the Canadian Council

Association.

2. I do challenge and rebut the argu-

ments and the recommendations of the said Council and the



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infringement on Individual Rights and as such are not Democratic and are not based on fact.

3. Fluoridation of public water supplies is contrary to the Canadian Bill of Rights, Bill C79, paragraph 2, clause (a):-

"the right of the individual to life, liberty, security of the person and the right not to be deprived thereof except by due process of law."

4. The procedure of adding Sodium Fluoride to the water supply is contrary to the right of the individual to choose that which he or she will take into their bodies by way of chemicals or drugs.

5. In his essay, "On Liberty", page 144 and 145, John Stuart Mills asserted one very simple principle: "that the sole end for which mankind are warranted, individually or collectively in interfering with the liberty of any of their number is self-protection, that the only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."

6. This basic principle embodied in the philosophy of John Stuart Mills is the basis of Democracy. It is this principle that is the difference between a Democracy and a Welfare State. It is the line of demarcation between where the state may exert power over the individual and where the individual is sovereign.

7. I would draw attention to page 5604 of sub-paragraph (3) of the brief of the Edmonton



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infringement on individual rights and as such are not

Democratic and are not based on fact.

3. Fluctuation of public water

supplies is contrary to the Canadian Bill of Rights.

"The right of the individual to life,

liberty, security of the person and the

right not to be deprived thereof except

by due process of law."

4. The procedure of making decisions

relative to the water supply is contrary to the right of

the individual to choose that which he or she will take

into their bodies by way of chemicals or drugs.

5. In his essay, "On Liberty," page 14

and 145, John Stuart Mill's asserted the very simple

principle: "that the sole end for which mankind are

warranted, individually or collectively in interference

with the liberty of any of their number is self-protection

that the only purpose for which power can be rightfully

exercised over any member of a civilized community is against

his will as to prevent harm to others. His own good,

either physical or moral, is not a sufficient warrant."

6. This basic principle enshrined in

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cracy. It is this principle that is the difference between

a Democracy and a Welfare State. It is the line of demar

cation between where the state may exert power over the

individual and where the individual is sovereign.

7. I would draw attention to page 1004

of sub-paragraph (3) of the draft of the Edmonton



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Fluoridation Council (published copy).

"Dental disease is a mass disease and requires mass methods of prevention. Fluoride administered on an individual basis is an inferior preventative to fluoridation."

8. I suggest that this statement is misleading on the following ground:-

(a) There is no such type of disease as a "mass disease". There are two types of diseases, contagious and non-contagious.

(b) The use of the term "mass disease" does not refer to either type of disease and does convey the impression that "dental disease" is contagious and is related to masses.

9. I do further challenge and rebut the statement "that fluoride administered on an individual basis is an inferior preventative to fluoridation", on the ground that it is misleading:-

1. (a) The comparison is not made in relation to the beneficial results of fluoride when administered on an individual basis as compared with those from fluoridation of public water supplies.

(b) but, from the angle of administration, and the intent must be construed to mean that "it is better to compel a whole populace to take a measure than to



Journal (published 2000)

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9. I do further challenge and reject the

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1. (a) The comparison is not made in relation to the beneficial results of fluoride when administered on an individual basis as compared with those from fluoridation of public water supplies. (b) But, from the angle of administration, and the intent must be construed to mean that "it is better to compel a whole populace to take a measure than to



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allow the individual freedom of choice."

10. This angle poses a question:-

Why should compulsion be exercised over a whole populace, for a disease that is not contagious, is not water-borne and which can be controlled individually? when -

preventative measures for diseases that are contagious and which cause death, such as Typhoid Fever, Scarlet Fever and Diphtheria, are not compulsory nor is it compulsory to take preventive treatment for polio, which is a disease that causes disability and also death.

11. As citizens of a Democratic country we have certain rights and freedoms and one of these is the privilege of contacting our doctor or our dentist to seek advice about our health problems and of deciding for ourselves whether we will accept their advice. And, in knowing, that if we do accept it, we have placed ourselves under their care if any adverse effects, due to personal conditions, arise.

12. It is further stated by the Edmonton Fluoridation Council, page 5605, paragraph 7:-

"In Canada approximately one person in eighteen is getting the benefits of water fluoridation. In the U.S.A. it is approximately one in five."

13. I do rebut this statement on the grounds that it is misleading, for the following reason:-



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1. (a) The percentage is arrived at by comparison of all the people who drink fluoridated water with the population of the nation.

(b) Fluoridation is only beneficial to a certain group of the population, children up to 10 years.

(c) The comparison is, then, void, since there is no relation between all the people who drink fluoridated water and the benefits.

14. It is further argued by the Edmonton Fluoridation Council (page 5605, paragraph 8) that:-

"although a public health grant for the control of cancer has been established through Dominion-Provincial Public Health grant arrangements, no such grant exists for the control of dental care through fluoridation. Yet, fluoridation is a proven preventative for dental caries, the cheapest and most effective available, while the control of cancer is presently based on treatment alone."

15. It is recommended by the Edmonton Fluoridation Council, page 5607, paragraph 5, and by the Canadian Dental Association respectively, that:-

1. (a) a public health grant for the purchase of fluoridation equipment be established under existing Dominion-Provincial Health Grant arrangements.



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the person who with the person

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(c) The person is 10 years

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(b) that: "provinces which make fluoridation compulsory should qualify for a federal grant of 50 percent toward the cost of operation. The province and municipality should split the remaining cost."

16. I DO MOST STRONGLY OPPOSE AND REBUT THE RECOMMENDATIONS and the argument as set out in paragraph 14, on the grounds that:-

1. The proposal is not democratic and the argument is not sound.

(a) Cancer is a disease that causes death. Much research is required to determine the cause of the disease and the method of cure. By reason of these characteristics, which place it in a special category, assistance is given towards the control of the disease by way of grants and free treatment.

(b) Dental caries has been termed by prominent dentists "to be a problem rather than a disease." It is a personal problem and can be controlled individually.

17. I would further support my argument with the following comparison:-

To plead for a grant for fluoridation (paragraph 14) of public water supplies by the aforementioned comparison is - the same as to request that treatment be



(b) that "provinces which make
fluoridation compulsory should qualify
for a federal grant of 50 percent
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To plead for a grant for fluoridation
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given for the common cold, because it
is given to Tuberculosis.

18. On the count of "Not Democratic"

I would draw attention to the intent of the Public Health
Act in relation to a water supply "to provide pure and
wholesome water" and -

19. I would further draw attention to
the following quotations from the judgments of Rand and
Cartwright, JJ. in the case of the Supreme Court of
Canada in Metropolitan Toronto v. Forest Hill (1957)
9 D.L.R. (2d) 113; J. Rand:-

"But it is not to promote the ordinary
use of water as a physical requisite
for the body that fluoridation is
proposed. That process has a distinct
and different purpose; it is not a means
to an end of wholesome water for water's
function but to an end of a special
health purpose for which a water supply
is made use of as an end."

J. Cartwright:-

"In pith and substance the bylaw relates
not to the provision of a water supply
but to the compulsory preventive medica-
tion of the inhabitants of the area."

20. In presenting the recommendation of
the Canadian Dental Association that "the provinces make
fluoridation compulsory", Dr. D.W. Gullett of Toronto,
the Association's Secretary, indicated it would prefer
action without referendum "because proven scientific



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statements are no match for unwarranted or groundless statements which verge on fear tactics."

21. I DO MOST STRONGLY CHALLENGE AND REBUT this statement on the grounds that it is not democratic and is not based on fact.

22. It is appropriate in replying to the statement made by Dr. Gullett to quote some excerpts from the essay, "On Liberty" by John Stuart Mills, page 152:-

"But the peculiar evil of silencing the expression of an opinion is that it is robbing the human race - posterity as well as the existing generation; those who dissent from the opinion, still more than those who hold it. If the opinion is right they are deprived of the opportunity of exchanging error for truth; if wrong, they lose what is almost as great a benefit, the clearer perception and livelier impression of truth, produced by its collision with error."

"We can never be sure that the opinion we are endeavoring to stifle is a false opinion; and, if we were sure, stifling it would be an evil still."

"The opinion which it is attempting to suppress by authority may possibly be true. Those who desire to suppress it, of course, deny its truth; but they are



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not infallible. They have no authority to decide the question for all mankind and exclude every other person from the means of judging. To refuse a hearing to an opinion because they are sure that it is false is to assume that their certainty is the same thing as absolute certainty."

23. "There are many prominent doctors, dentists and scientists who do not endorse the safety of fluoridation. The effects of fluoridation from long-term use (over a lifetime) and the possible adverse effects in relation to other diseases such as diabetes, cancer, etc., is still not known.

24. The fact that there is conflicting opinion among medical men and scientists would pose a signal for caution in the use of any drug or chemical which we might take by choice.

25. Fluoride in water. "It has been argued by the proponents of fluoridation that water in some areas is deficient in fluoride. But, fluoride is not a component part of water, but is a natural element found in the soil and in the water in certain areas, the same as iron, sulphur or other elements.

26. If we say water is deficient in fluoride, then, we can say with equal truth that "water is deficient in iron or any of the other elements." There is not a standard quality of water for all areas but water that, like soil, is of a different type in that it is suited to the other conditions of the area.



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27. Many foods contain fluoride, two of which are fish and tea. It would seem reasonable then to assume that many people are already getting a sufficient amount of fluoride for their body requirements and some may be getting more.

28. It is stated by the proponents of fluoridation that the recommended dosage for fluoridation of public water supplies, of 1.p.p.m., is a safe dosage, but on what basis? This theory is based on information deducted from calculations of the amount of food and water consumed by the average person, and without consideration of other factors, such as the fact that the concentration of Sodium Fluoride in water increases with boiling.

29. People are NOT averages, they are individuals, with different habits of eating and drinking, different ailments, physical stamina and different environments of work, thus -

the recommended dosage of fluoride of 1.p.p.m. as being a safe dosage for all simply means that it is considered safe for the average person (and this is still questionable) and NOT that it is safe for everyone.

30. Responsibility. It has been recommended by the Edmonton Fluoridation Council, page 5607, paragraph 4, that:-

"The Minister of National Health and Welfare and the Provincial Ministers of Health discharge their responsibilities



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to the public by making official public statements about the safety, effectiveness and low cost of fluoridation."

31. I DO MOST STRONGLY OPPOSE AND REBUT THIS RECOMMENDATION on the ground that:-

1. It is not Democratic:

(a) The aforementioned Ministers have a responsibility to all the citizens of Canada. One of these is the duty, under the Public Health Act, "to supply pure and wholesome water."

(b) It is also the duty of the Ministers of Health to make known to the public health measures that are available, but IT IS NOT THE DUTY of the said Ministers to indoctrinate the public by pressure or persuasion, through educational programs, to sway public opinion towards a certain measure. The people ~~are~~ are entitled to know all the facts, assess the information and form their own opinions.

2. I do further contend that:-

(a) the said Ministers would, in undertaking to launch a program to promote fluoridation, be contrary in the performance of their duty, in that:

(b) the Nature of the Fluoridation is contrary to the intent and purpose of the Public Health Act "to supply pure



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ness and low cost of fluoridation.

31. I DO NOT STRONGLY OPPOSE AND WANT

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and wholesome water."

32. Fluoridation, Discontinued. The use of fluoridation as a preventive measure for dental caries has not convinced the citizens of many cities and communities of the benefits of the measure.

33. Many cities and towns in U.S.A. have, after installing fluoridation equipment and using fluoridated water for various periods of time, discontinued its use.

34. In Sweden (December, 1961) The Supreme Administrative Court unanimously declared: "fluoridation of public water supplies illegal." Instructions to the county administration require discontinuance of the sole fluoridation experiment established in Norrkoping in 1952.

35. It was suggested by Dr. D.W. Gullet of Toronto, Secretary of the Canadian Dental Association, in presenting the Association brief, that:-

"people undoubtedly are being paid to promote opposition to fluoridation schemes."

36. As one of the citizens who are opposed to fluoridation of public water supplies I DO MOST STRONGLY CHALLENGE AND REBUT this suggestion.

37. Those of us who worked in two campaigns against fluoridation in Regina (and in which the measure was defeated both times) did so from concern for the fundamental freedoms involved and the knowledge that it was our responsibility to bring our viewpoint before the public.



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before the public.



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38. The campaign was financed from donations obtained by a canvass of individual citizens, homes and business places, and from personal contributions by those who were working in the campaign. The people who worked often made additional personal contributions to cover expenses of the campaign.

39. The literature which was distributed and which we quoted from in our campaign was NOT of a type to arouse fear or hysteria but was factual reference to statements made by doctors, dentists and scientists, some of whom we had been in contact with.

40. Other literature was mimeographed and was made up of quotations from the aforementioned professional men and simple facts in relation to fluoridation from the angle of individual freedom, and in comparison with public health measures of pasteurization of milk and chlorination of public water supplies. (I do not have a sample copy of this literature).

41. I have, in an appendix, submitted samples of some of the literature used in the campaigns in Regina in 1954 and 1958 and also of other pamphlets on fluoridation of public water supplies. I have also submitted copies of letters to the Editor (Reader's Comments), the Leader-Post. The letters do not constitute a page or partial page of the paper but are copies of letters which appeared in the paper in 1958 and in 1961 (and one or two of which I do not have the date) which I put together in the present form and had photographed.

42. I have also submitted, as an exhibit, copies of pamphlets in support of my argument



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and was made up of quotations from the statements of professional men and private tests in relation to fluoridation from the angle of individual freedom, and in comparison with public health measures of sanitation of milk and chlorination of public water supplies. I do not have a sample copy of this literature.

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AGAINST FLUORIDATION.

Conclusion

I have endeavoured in this supplementary and rebuttal brief to show by reference, by quotation and by comparison that the recommendation for and in relation to Fluoridation of Public Water Supplies, as proposed by the Edmonton Fluoridation Council and the Canadian Dental Association, is not democratic and is an infringement on individual freedom. I have also, by presentation of facts and by comparison, attempted to prove that some of the statements made by the aforementioned Council and Association, in support of the recommendations proposed, are misleading.

My rebuttal argument has not been prompted by fear or by a desire to cast reflection on those doctors, dentists, professional men and individuals who hold an opposing viewpoint to the one endorsed by myself but by the privilege and responsibility to defend my rights as a free citizen.

I would ask that, in your consideration of the recommendations for Fluoridation of Public Water Supplies, the sense of urgency that surrounds fluoridation and the role of being a preventive measure which cannot be met by other methods be laid aside and the measure viewed from its proper perspective, dental caries, a problem, but also a personal problem and one that is caused to a large extent by wrong eating habits, the excessive consumption of sweets and of soft drinks and by faulty dental habits.

I would suggest that the aforementioned



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I would ask that, in your consideration of the recommendations for fluoridation of Public Water Supplies, the sense of urgency that surrounds fluoridation and the role of being a preventive measure which cannot be met by other methods be laid aside and the following facts be given your consideration:

a problem, but also a personal problem and one that is caused to a large extent by wrong eating habits, the excessive consumption of sweets and of soft drinks and by faulty dental habits.

I would suggest that the aforementioned



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TORONTO, ONTARIO

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factors be made known to the public and that remedies which the individual can obtain, such as fluoride tablets, also be made known and the individual encouraged to assume responsibility to meet the problem.

For those who are unable to provide these services for themselves (but I understand that fluoride tablets are quite cheap) I would suggest that the recommendations made in my original brief to this Commission (page 7, paragraph 26) and in which freedom and responsibility are the guiding principles, be adopted.

Respectfully submitted - Grace Stewart.



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which the individual can obtain, such as fluoride tablets,
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These services for themselves (and, understanding that
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the recommendations made in the original report to this
Commission (page 7, paragraph 13) and in which freedom
and responsibility are the guiding principles, be
adopted.



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THE CHAIRMAN: Thank you very Miss Stewart. In coming before us with this rebuttal statement you certainly exhibited fortitude coming to this part of Canada all the way from Regina to make this presentation.

Now are there any other factors, or any other matters you may want to draw to our attention here this afternoon?

MISS STEWART: I believe there is one I would like to draw to your attention, after hearing the submission by the Canadian Insurance Association. I would like to mention the plan that I recommended in my original brief based on assistance to the needy through income tax control.

By this I mean that those who desire assistance would apply to the Federal Government, and the Federal Government would investigate from the records, either their income tax or from their unemployment insurance, and they have officers, I understand, that go out and investigate whether a person is in need.

The plan could be operated from that set up, and it would be less costly than a compulsory plan.

THE CHAIRMAN: Have you any view to put forward Miss Stewart as to the operation of the program now going forward in Saskatchewan?

MISS STEWART: Yes, I have.

THE CHAIRMAN: I take it being from Regina you had an opportunity to observe these things?

MISS STEWART: Yes, I have. Many of



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our best doctors - well by saying "best" I do not mean to reflect on the ones that are left, but many good doctors have left the Province and if the doctors and the people are both unhappy, there is a tendency among the people to say what can we do? We cannot do anything now.

For myself, I experience, when I go to a doctor's office and sit in the waiting room, I feel as if I am one of the indigents. This is not because of the attitude of my doctor. This is just the fact that we are all brought down to the level of the indigent.

Many irresponsible people seek help just because they are irresponsible and they have not made the effort they should to pay their bills and when they get services under a Government plan, they are inclined to take all they can get for nothing; to make trips to a doctor's office that they would not otherwise do. It puts all of us in the same class. We are sitting in their waiting room, you have not got the same sense of self-respect or dignity that there is when you are choosing your own plan and paying your way. More or less all just one class.

THE CHAIRMAN: In this matter of the doctors leaving, are you aware of these things from personal experience?

MISS STEWART: Yes.

THE CHAIRMAN: Are you going by hearsay in this regard? Is it from your personal experience?

MISS STEWART: Yes. This is personal knowledge. The place where I stay, my landlord and his



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daughter, their doctor has gone to the States. He is a very well liked doctor. They had great faith in him. It means they will have to seek someone else now.

THE CHAIRMAN: Have you any views on the operation of what was formerly the doctor sponsored plan that is now still in operation as a medium for payment to the doctors? Like the medical services group medical plan?

MISS STEWART: I am very pleased that these plans are allowed to operate to that extent myself. I would much sooner have had them not been allowed to operate fully and have to choose whether they wanted a Government plan or under the voluntary ones, but as they are now we can pay our fee to these plans and they will look after the payment of the doctor.

We do not have the trouble of seeking a refund from the Government after we pay the doctor and the Government does not have the same control over our bills. They do not handle the bills. They are handled by the agency.

THE CHAIRMAN: Have you had any experience yourself with that? Is it actually in operation?

MISS STEWART: I understand it is. I have paid into medical services.

THE CHAIRMAN: You have joined it?

MISS STEWART: Yes. I was already in it but I have not presented any bills. I have not had any experience that way.

COMMISSIONER GIRARD: I do not know whether this is a fair question. You do not have to



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whether this is a fair question. You do not have to



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answer it if you do not want to. You were expressing just now the idea that you had to sit and wait in a doctor's office and that was not very pleasant. Have you found any other change in the care that you are receiving from your doctor? Not that he would not be the same good doctor, if he were a good one before, but by the pressure of cases; he would have to see a lot more people or that he could not give you the time that he used to give you before. Is there anything in that that you have noticed?

MISS STEWART: I would like to correct something. Maybe I gave you the wrong impression when I said I was waiting in the doctor's office. There was nothing any different in the waiting room but the fact that some of those people waiting in there might have been those that were just there to see the doctor to get all they could out of the plan. You are all in one group.

The public does not know what you are there for. You are just a levelled out group.

THE CHAIRMAN: They might well have been very genuine patients.

MISS STEWART: Yes, they might have. Then again, there is that feeling in the air that anything that is controlled by the Government some people are going to get all they can back.

COMMISSIONER GIRARD: This is in the waiting room. What about in the doctor's office?

MISS STEWART: This is all right because the doctor knows me and I know him. There is no



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change there.

COMMISSIONER GIRARD: ... There is no change in the relationship between your doctor and yourself?

MISS STEWART: No.

COMMISSIONER GIRARD: ... And there is no change in the kind of service you are getting?

MISS STEWART: No, certainly not.

COMMISSIONER BALTZAN: ... I have no questions Mr. Chairman. I just wanted to compliment you Miss Stewart on your balance and counterpoise between theory and reality. I am very much impressed. I am also very grateful to you for having modified an earlier statement that all the best doctors have left Saskatchewan because that hits a tender spot.

THE CHAIRMAN: Dr. Baltzan does not know just how long we are going to keep him.

Thank you again Miss Stewart. We are obliged to you. We have felt that the individual persons who, as individuals, have come before us have been very helpful. There have not been too many of them, in the sense we would have liked to have seen more people with individual views, because it is this composite of the individual view, and others as well, that we are trying to get. Thank you very much.



COMMISSIONER GLASS: There is no

change in the relationship between your letter and your
self?

change in the kind of service you are giving?
MISS STEWART: Yes, in a very definite
COMMISSIONER GLASS: And no

questions Mr. Chairman. I just wanted to complement
you Miss Stewart on your patience and composure be-
tween theory and reality. I am very much impressed
and also very grateful to you for having notified an
earlier statement that all the best doctors have left
Saskatchewan because that was a tender spot.

THE CHAIRMAN: Mr. Batten does not know

just how long we are going to keep him.

Thank you again Miss Stewart. We are

obliged to you. We have felt that the individual person
who, as individuals, have come before us have been very
helpful. There have not been too many of them in
the sense we would have liked to have seen more people
with individual views, because it is this composite of
the individual views of others as well, that we are



Bardwell

12897

THE SECRETARY: Mr. Chairman, the next submission is from Mr. K. O. Bardwell. This will be known as Exhibit R-5. Mr. Bardwell will read his submission and also I think he wishes to delete paragraph 2 of the submission.

MR. BARDWELL: That is right.

EXHIBIT No. R-5: Submission by Mr. K. O. Bardwell

SUBMISSION BY MR. K. O. BARDWELL

Appearance: Mr. K. O. Bardwell

MR. BARDWELL: Mr. Chairman, members of the Commission, if I might read this, it is only a few pages?

THE CHAIRMAN: Yes.

MR. BARDWELL: When the members of this Royal Commission held your first public meeting in this hall last fall I appeared before you to ask that you consider only plans which would offer the general public health care equal to or better than that available to the employees of the Government of Canada. By that I mean under the Public Service Medical Scheme. I recall then noting what I considered to be important gaps among the ranks of those one might have expected to have something to say on future health plans for Canadians. First of these was the absence of any representative of one major province; second, the complete absence of any representatives of the cities and municipalities across Canada. Thirdly, I remarked on the general absence of spokesmen for those religions which are not involved in the operation of hospitals. This refers only to the initial terms of reference because you have had briefs from some since.



THE SECRETARY: Mr. Chairman, the next

submission is from Mr. O. Bardwell. This will be known as Exhibit 8-7. Mr. Bardwell will read his submission and also I think he wishes to deliver paragraph 3 of the submission.

EXHIBIT No. 8-7 Submission by Mr. O. Bardwell

PROPOSITION BY MR. O. BARDWELL

MR. BARDWELL: Mr. Chairman, members

of the Commission, if I in this regard, as is only a few pages?

THE CHAIRMAN: Yes.

MR. BARDWELL: Then the members of this

Regional Commission held your first public meeting in this hall last fall I appeared before you to ask that you consider only plans which would offer the general public

health care equal to or better than that available to the

employees of the Government of Canada. By that I mean under the Public Service Medical Scheme. I recall then noting what I considered to be important gaps among the ranks of those one might have expected to have something to say on future health plans for Canadians. First of these was the absence of any representative of one major

province; second, the complete absence of any representatives of the cities and municipalities across Canada. Thirdly, I remarked on the general absence of spokesmen for those regions which are not involved in the operation of hospitals. This refers only to the initial terms of reference because you have had little from some since.



Bardwell 12898

Second, I mentioned the municipalities.

It is not so clear just why they ignored the terms of reference meeting and later failed to put in briefs, other than the notable exception of Toronto, to state their problems connected with health care and welfare situations arising from ill health. The City of Ottawa, which seems to have more than its share of hospital crises headlines, did not appear. You should note, however, that Mayor Whitton says there is now not a hospital bed shortage but a hospital staff shortage. This may be true if a drastic re-organization of services were implemented to give much broader out-patient services. The prime reason for patients being hospitalized often appears to be the need to get the services paid for by the province or an insuring agency. Reasonably, if the patient were insured for the broadest range of out-patient diagnostic and treatment services many beds would be freed. It is also probable that people who fear actual hospitalization might then go to the hospital clinic early enough for treatment to be effective. Probably less man-days would be lost from productive work by people with less serious medical problems.

Third, I mentioned the churches and their silence at that first hearing. In my earlier appearances I listed religious reasons for having presumed to put the case for giving everyone proper health insurance protection. I was most annoyed to read the brief presented belatedly in Toronto by the Anglican Church and since some of the things I must say about it are harsh, I will detail my reasons. In opening their submission the Church spokesman expressed their assurance that the necessary viewpoints on health care will be



Bardwell 12899

expressed by "medical and other authorities." In their work at the parish level clergymen are aware of the suffering brought about by the costs of adequate medical care. They know that for many religion is the only hope because their finances will not stretch to cover solutions that are practical for people who are insured or are more financially secure. The clergy also know that they and their families are covered by group insurance plans and they must know that many others are not and cannot be covered by the same type of policies. This brief evidenced a lack of compassion for the suffering of their flocks.

I have said that the Anglican Church had no recommendations to make that dealt with national health in the physical sense. I find this most curious when one considers that the Chairman of the Committee presenting the brief was a medical doctor, an insurance company medical referee. Why was it necessary to have such an authority work on a brief which dealt with neither health nor insurance? The one material suggestion of the brief is, however, equally curious. They suggest that the Government of Canada should spend some \$40,000 annually to set up for the clergy a sort of Spiritual Fitness Grant to train churchmen in their hospital duties. One wonders what will be included in this curriculum.

I now move to meet the statements of those who have said that facilities already exist to meet the medical needs of all. Their attitude is a modern parallel of Dickens' best-known character,



198-10

March 11

expressed by "medical and other authorities." In their

work at the parish level clergymen are aware of the suffering brought about by the costs of adequate medical care. They know that for many religion is the only hope because their finances will not stretch to cover solutions that are practical for people who are insured or are more financially secure. The clergy also know that they and their families are covered by group insurance plans and they must know that many others are not and brief evidenced a lack of compassion for the suffering

had no recommendations to make that dealt with national health in the physical sense. I find that most curious when one considers that the Chairman of the Committee company medical referred. Why was it necessary to have such an authoritative work on a brief which dealt with neither health nor insurance? The one material suggestion of the brief is, however, equally curious. They suggest that the Government of Canada should spend some \$40,000 annually to set up for the clergy a sort of Spiritual Fitness Grant to train clergymen in their hospital duties. One wonders what will be included in this curriculum.

I now move to meet the statements of

those who have said that facilities already exist to meet the medical needs of all. Their attitude is a modern parallel of Dickens' best known character,



Bardwell

12900

businessman Scrooge, who asked why the poor did not use the prisons, the union workhouses, the treadmill and the Poor to the limits provided out of his beneficence. The answer is still the same: "Many can't and many would rather die." "If they would rather die," said Scrooge, "they had better do it and decrease the surplus population. Besides," (remembering his public image) "excuse me -- I don't know that."

I will not go into detail to refute the contentions of the various medical and business associations that any plan must be voluntary. I have characterized this as an impassioned defence of the Canadian's sacred right to die a public charge. I doubt if I can improve on this phrase. I would, however, call to the attention of this group the very severe limitations on the mobility of any Canadian who is receiving care under a private or provincial plan. During the recent thalidomide crisis many writers found it disturbing to think that children born in one province might get less benefits, or none, because they were born in the wrong area. This situation exists throughout our (Canadian) society. Some are adequately covered, others are not. The well may move, the sick and their families may not. Loss of freedom of movement is a severe punishment, inflicted without cause, just because we have no national health plan.

I would point out to you that although much criticism of the British National Health Plan was heard in Canada during the year it is significant that none of it came from British immigrants other than



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businessman Sorensen, who asked why the poor did not use

the system, the answer was that the system was not

poor to the limits provided out of his beneficence. The

answer is still the same: "Many cannot... and many would

rather die." "If they would rather die," said Sorensen,

"they had better do it and decrease the surplus population."

It is a very common answer to the question of why the poor

do not use the system: "I don't know."

I will not go into details as to why

the contentions of the various medical and business

associations that any plan must be voluntary. I have

characterized this as an impassioned defense of the

Canadian's sacred right to die a peaceful death. I doubt

if I can improve on this phrase. I would, however, call

to the attention of this group the very severe limitations

on the mobility of any Canadian who is receiving care

in a hospital. The limitations are of two kinds: physical

limitations and financial limitations. It is disturbing to

think that children born in one province might get less

benefits, or none, because they were born in the wrong

province. This is a very serious situation.

Society. Some are adequately covered, others are not.

The well may move, the sick and aged families may not.

Loss of freedom of movement is a severe punishment.

inflicted without cause, just because we have no national

health plan.

I would point out to you that although

much criticism of the British National Health Plan was

heard in Canada during the year it is significant that

none of it came from British immigrants other than



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TORONTO, ONTARIO

Bardwell

12901

doctors and none of that came from officials of the British Medical Association. This, it seems to me, leaves some spokesmen in Canada flailing at straw men.

In my briefs I mentioned national pride as a reason for suggesting a plan for rapidly instituting health insurance. I would call to your attention the continued existence of the Keep Our Doctors lobby, which now proposes to extend its activities into other provinces. The Save Our Saskatchewan Committees formed during the spectacle out west this summer were an indication that the present method of arriving at compromises had worn out the non-belligerents. The ridiculous posturing of men who know that compromise is inevitable annoys the rest of the nation as well. When a board to control the functions of the National Health Act which logically should result from this enquiry is set up I hope the interested groups will be represented by men and women who will concede the right of the work they are named to do, people who are capable of thinking of the good of their country above the present interest of the groups they represent. Further quibbling will not help our national image at home or abroad ... nor will it help us to do our duty by our fellow man. In presuming to come before you to represent the interests of the unorganized and inarticulate consumers of medical services I have found it necessary to speak harshly of the corporate attitudes of many groups. I want to say now that little of this was intended as criticism of individuals with whom I have had personal contact and



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TORONTO, ONTARIO

Bardwell 12902

that I do not really believe that they subscribe to the beliefs promoted by the organizations which purport to speak for them. I do hope that the end of this hearing will see an end to these promoted animosities and that the best intentions of all those who have appeared before you will be used to develop a health plan of which we may be proud. You may be sure that Canada will remember you by the report which you must now write. May God help you in your duty!

KOB.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Bardwell 12903

THE CHAIRMAN: Thank you Mr. Bardwell.

There is an observation I think I ought to make. You refer to the submission of what you call the Anglican Church having been belatedly made in Toronto. In all fairness that was the logical place for the submission to be made.

MR. BARDWELL: If I may say so sir I would think the logical place for the Church to express its interests would have been at the terms of reference meeting.

That is when I expected to see them here.

THE CHAIRMAN: I think I should say that would have been a misinterpretation of the invitation which we extended for that first meeting because we never intended that that should be a meeting at which formal presentations would be made.

We were only getting the lines upon which we would proceed, and that kind of thing, at that meeting.

Then the reference to what you call the Spiritual Fitness Grant of course came before us at Edmonton. Well it was originally in Calgary but it was submitted to us in Edmonton in February at one of our earliest hearings for the chaplaincy service. The training of personnel for chaplaincy service of all denominations, the background being that a chaplain had a function to perform in a hospital and that there was therapeutic value in the presence of a chaplain, and this is the way that proposition first came to the Com-

THE CHAIRMAN: Thank you, Mr. Bartholomew.

There is an observation I would like to make. You refer to the submission of your bill to the American Council having been initially made in 1942. In all fairness that was the right place for the submission to be made.

MR. BARTHOLOMEW: I may say as well

I would think the logical place for the Church to discuss its interests would have been at the time of revision.

That is what I expected to see then.

THE CHAIRMAN: I think I should say

that would have been a misinterpretation of the invitation which we extended for that first meeting because we never intended that that should be a meeting at which formal presentations would be made.

We were only getting the ideas upon which we would proceed, and that kind of thing, so that

then the reference to what you said

the spiritual fitness of our people before us at Liberton. Well, it was originally in 1942 but it was submitted to us in Edmonton in February, so one of our earliest hearings for the chaplaincy service. The training of personnel for chaplaincy service at all

is a function to perform in a hospital and that there was a respect value in the presence of a chaplain, and it is the way that proposition came to the Com-



Bardwell 12904

mission. Then it was supported in the brief at Toronto.

Now do you wish to add anything more?

MR. BARDWELL: Yes sir. If I may comment on the brief of the Health Insurance people this morning. I believe in my earlier brief I did mention the cost of the civil service group plan, serving as a model. I notice these people mention also that the civil service group plan had now established costs on quite a broad basis.

THE CHAIRMAN: Are you in a position to tell us Mr. Bardwell, from the experience of the operation of that plan, has there been an increase in the coverage?

MR. BARDWELL: The gross medical benefit has been doubled during the period of the operation of the plan. It went from \$5,000. to \$7500. and now is \$10,000.

THE CHAIRMAN: You are referring to that in terms of the \$5,000.00; the insurance people recommended this policy as the overall policy?

MR. BARDWELL: Well in our plan in the civil service the total payable benefits are now \$10,000. and I believe in the recommended plan of theirs it is \$5,000.

THE CHAIRMAN: Have you any figures at all Mr. Bardwell as to the percentage, or in some way of defining what might be the number of those who have claims in excess of \$5,000.00?

MR. BARDWELL: I understand that there have been people who have hit the ceiling and gone



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have been people who have hit the ceiling and gone

MR. BARDWELL: I understood that

have claims in excess of \$2,000,000

way of collating what might be the number of those who
at all Mr. Bardwell as to the percentage, or in some

THE CHAIRMAN: Have you any figures

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\$10,000, and I believe in the recommended plan of theirs
the civil service the total payable benefits are now

MR. BARDWELL: Well in our plan is

recommended this policy as the overall policy.

that in terms of the \$2,000,000, the insurance policy

THE CHAIRMAN: You are referring to

is \$10,000.

of the plan. I went from \$2,000,000 to \$2,700,000, and now

benefit has been doubled during the period of the operation

MR. BARDWELL: The same method

the coverage

operation of that plan, has there been an increase in

to tell us Mr. Bardwell, from the operation of the

THE CHAIRMAN: Are you in a position

quite a broad basis.

civil service group plan had considerable costs.

model. I notice the comparison also that the

the cost of the civil service group plan, compared with a

morning. I believe in the earlier period I had a question

comment on the part of the House of Representatives people this

MR. BARDWELL: Yes sir. In I may

now do you want to add anything more?

Then it was supposed to be the first at Toronto.



Bardwell 12905

beyond. I believe one customs officer went beyond while the ceiling was at \$7500. for his wife's medical expenses and the \$10,000. provision came through just in time to pick up the bills and carry her for a while longer.

THE CHAIRMAN: Do you think the figures would be available from which we could ascertain how many were above \$5,000.00?

MR. BARDWELL: Yes. The Manager of the Committee is very co-operative and, in fact, at an earlier stage should you have been more inquisitive, I could have asked him to appear here. He was quite agreeable providing, of course, that Treasury gives clearance. A routine thing.

THE CHAIRMAN: If there is anybody more inquisitive than this group, I think they are hard to find.

MR. BARDWELL: If I may proceed. In another item in our brief they mention income tax exemptions as the basis of rating the need for indigent people. I remember in particular an editorial on the question of income tax as it is actually paid in the various provinces. I think you are all aware of the fact that there is some dispute as to whether the declared income is a true barometer of what people do earn, and I think this would work an injustice in some areas, because there are some areas in the country which do not pay their proportionate share of their incomes.

COMMISSIONER BALTZAN: Maybe it would work a justice rather than an injustice.



beyond. I believe one custom officer went beyond while
the ceiling was at 2-100 for his wife's medical ex-
penses and the 210,000. Now when times are tough just in
time to pick up the bills and carry her for a while

THE CHAIRMAN: Do you think the figures
would be available from which we could ascertain how
many were above 25,000?
MR. BARNETT: Yes, the number of
the Committee as well as officers and in fact, at
an earlier stage should you have been more representative,
I could have asked him to appear here. He was one of
agreeable providing, of course, that Treasury gives
clearance. A routine thing.

THE CHAIRMAN: If there is anybody
more inductive than this group I think they are hard

MR. BARNETT: If I may, please, in
another item in our brief they mention income tax ex-
emptions as the basis of raising the need for indigent
people. I remember to participate in a discussion of
the question of income tax as it is actually paid in the
various provinces. I think you are all aware of the
fact that there is some dispute as to whether the de-
clared income is a true barometer of what people do
earn, and I think this would work an injustice in some
areas, because there are some areas in the country which
do not pay their proportionate share of their incomes.



Bardwell. 12906

MR. BARDWELL: Well, it might work a justice. I think there would be more prejudice on that.

On another question, I believe you asked one of the spokesmen whether mobility would be hindered under their proposed scheme. Well, when you change schemes the hindrance usually comes in waiting schemes, unless you have a reciprocating scheme from coast to coast. I do not think it is a definite hindrance as to mobility.

The other item there is limit of coverage after a person leaves employment. In the present practice this certainly limits mobility; people cannot leave jobs, because if they have someone in the family who is sick they cannot leave their jobs. My own income tax statement last year had \$1,800. medical expenses on it, the government and I just about broke even. It is a definite hindrance. I cannot leave my job.

On the question of compulsion, many of us find ourselves concerned with pride and ridicule and other factors in having insurance. I find it is a force of compulsion that some people do not get coverage. The people who never carry insurance often end up with being indigents, society has lost any benefit of any employment they may have.

THE CHAIRMAN: Let me put it to you. Just what type of program do you recommend, you as an individual or whoever you may wish to represent?

MR. BARDWELL: I am speaking as an individual. My position was a very simple one, that I do not think I should recommend a plan which offers to the



Bardwell 12907

general public of Canada any less benefits that the public of Canada gives ----

THE CHAIRMAN: I quite understand that. How are you going to pay for it? On a premium basis?

MR. BARDWELL: Yes, a premium basis, with only the inability to pay through employment as an exempting factor, that is health, age or the current state of the economy. This, incidentally, would give government some incentive to see that everyone was well and working.

THE CHAIRMAN: You see only two classes, those who work and pay premiums, those who are not working and having their premiums paid for them?

MR. BARDWELL: No, not for those who are working - I am sorry, I thought you were referring to the present situation. You are talking of this projected situation.

THE CHAIRMAN: Yes.

MR. BARDWELL: Yes, this is about it.

COMMISSIONER BALTZAN: Just one question, Mr. Bardwell. You refer to a quotation by Mayor Whitton that there is not now just a hospital bed shortage but also a hospital staff shortage.

MR. BARDWELL: Yes, sir.

COMMISSIONER BALTZAN: Do you know that the outpatient services have not been extended?

MR. BARDWELL: No. In spite of the Mayor's statement, you have a considerable bed shortage here. At any rate, a number of the doctors of the Academy have stated that there is, in fact, a shortage.

general public of Canada say that benefits that the public

THE CHAIRMAN: ...

How are you going to pay for it? On a premium basis?

MR. BARNETT: ...

with only the inability to pay through employment in an

exempting factor, that is health, age or the current

state of the economy. If the Government would give

Government some incentive to see that people who are well

and working

THE CHAIRMAN: ...

those who work and pay premiums, those who are not working

and having their premium paid for them?

MR. BARNETT: ...

are working. I am sorry, I thought we were referring to

the present situation. Yes, I think in this projected

MR. BARNETT: ...

MR. BARNETT: ...

COMMISSIONER BARNETT: ...

Mr. Barnett: You refer to a shortage of beds in hospitals

that there is now just a hospital bed shortage but

also a hospital staff shortage

MR. BARNETT: ...

COMMISSIONER BARNETT: Do you know

that the carpenter services have not been extended?

MR. BARNETT: No, in spite of the

Mayor's statement, you have a considerable bed shortage

here. At any rate, a number of the doctors of the

Academy have stated that there is, in fact, a shortage



Bardwell 12908

THE CHAIRMAN: What you are saying is that the Mayor's statement is not correct?

MR. BARDWELL: I would say that, yes.

THE CHAIRMAN: There is either a shortage of beds or there is not.

We want to thank you for coming, Mr. Bardwell.

The deleted paragraph would have provoked some questioning.

MR. BARDWELL: Perhaps I should explain my reasons for deleting that. I have not the clipping which would have verified that. I moved only three weeks ago, one of my files is still missing, and I could not verify it; and, secondly, due to the situation across the river at the moment where they have an election campaign it would not be particularly tactful to mention it anyway.



Wodehouse 12909

THE SECRETARY: Mr. Chairman, the next submission is from the Canadian Medical Association, and Dr. Wodehouse will come forward and introduce his group and speak to the submission, which will be numbered R-6.

--EXHIBIT No. R-6: Supplementary Submission
of the Canadian Medical
Association

SUPPLEMENTARY SUBMISSION OF THE CANADIAN
MEDICAL ASSOCIATION

Appearances: Dr. G. E. Wodehouse
Dr. T. J. Quintin
Dr. J. A. McMillan
Dr. L. R. Rabson
Mr. B. E. Freamo

DR. WODEHOUSE: Mr. Chairman and the members of the Commission, I think you are familiar with all my colleagues here, but I will re-name them.

Dr. Quintin, Chairman of the General Council; Dr. McMillan, City of Charlottetown; Dr. Rabson, from Winnipeg; Mr. Freamo, our Secretary of Medical Economics.

Mr. Chairman, ours is a relatively brief submission, indicating our programs and changes which have occurred since we appeared before you.

I would like, with your permission, Mr. Chairman, to read it in its entirety.



Wodehouse 12910

Mr. Chairman and members of the Royal
Commission Health Services:

1. The Canadian Medical Association is
glad to take advantage of this opportunity to present a
supplementary submission.

2. The C.M.A. originally requested a
Royal Commission enquiry into health services because
we felt that

a) The complexities of this problem
could only be unravelled and elucidated
by such an enquiry.

b) From this study needs could be found
and outlined and priorities established.

c) The best methods of meeting these
needs and priorities could be studied and
means of accomplishing the established
objectives could be recommended.

d) The decisions which might affect
public policy in the health field could
best be arrived at in an atmosphere
devoid of partisan considerations.

If I may add one remark of my own.

In addition to those, I think it was our feeling that it
would be desirable to take the matter of health services
out of the field of competitive politics and try to free
it from partisan and other considerations immediately.

3. We are aware of the range and diver-
sity of views on the absorbing topic of health and health
services which have been placed before the Commission
and while we may disagree with some of them, it is not



Wodehouse

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our purpose to challenge, rebut or refute the presentations of our fellow citizens who have testified. Health is obviously everybody's business. We would, however, remind you of the special interest and knowledge which practitioners of medicine have in both general and special areas of the problems which you are studying and we submit herein a brief restatement of our considered opinions as well as a summary of changes in services and methods which have occurred since the Commission commenced its study.

4. We believe it is obvious that the sole control of finances of health and medical services by any single body, be it governmental or otherwise, implies the distinct possibility of complete control of the standard of health care and medical practice. We believe that the welfare of patients, as determined by the quality of care is more likely to be affected adversely where there is only one source of funds for the payment of such services. For example, under the Hospital Insurance and Diagnostic Services Act there is evidence that government agencies go beyond their intended purpose and soon become sources of coercive regulations from which there is no appeal.

5. It is evident that many submissions to this Royal Commission have assumed that the prime purpose of your studies was embodied in your specific terms of reference (g) and (h) and an inordinate amount of testimony has been heard in this connection. We have placed before you a description of methods of financing health care services by professional medical associations



Wodehouse

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and have indicated our estimate of the costs of their extension to make them universally available. In the discussion which followed many of the statements made to you on the subject of medical services insurance it was quickly evident that a clarification of the phrase "doctors' bills" revealed that physicians' fees represented only a small and manageable proportion of the total cost of illness. Other goods and services provided over lengthy periods appear to loom large in total costs, which is one important reason why insurance for Extended Health Benefits is gaining in popularity. If this summary submission appears to follow the trend toward concentration on health insurance it is because we feel it necessary to spell out in greater detail and in proper perspective our opinions on medical services insurance and how it should be provided.

6. In our main submission we pointed out the need for improvements in many areas of health services simultaneously and on a broad front, with due regard to the resources available to implement the improved services. Having made this general qualification, we stated that nevertheless we considered it feasible and desirable to establish relative priorities and we undertook to indicate our views on the sequence which would be most desirable and necessary.

7. As the first requirement we grouped Personnel, Education and Research and illustrated the need for adequate numbers of trained health workers by portraying the foreseeable future need of Canada for physicians. A study on this subject was filed as an



Wodehouse

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exhibit early in your deliberations at the Halifax public hearing. We are aware that many other organizations representative of other health workers have similarly projected their requirements to permit them to take part in "methods of ensuring that the best possible health care is available to all Canadians." Such additional consideration as we have been able to give serves to confirm that adequacy of personnel is vital, that the quality of their training is very important, that it would be most unwise to depend unduly on extraneous sources, that our training facilities require amplification and that the recruitment of well-qualified candidates needs to be actively pursued. In the education of physicians and in the education of certain other health workers research is so intimately bound up with the educational process that attempts to separate it are damaging. We re-emphasize the desirability of providing progressively increasing financial support of medical research from public funds.

8. Second in our list of priorities we placed more adequate institutional health facilities. We recommended a selective building program for active treatment hospital beds, much more adequate facilities for the care of chronic, convalescent and other long-stay patients and the construction of relatively small units for the care of patients suffering from mental illness, all in the closest relationship to active treatment general hospitals. Capital expenditure for these purposes will be and should be large but the simultaneous development of home care programs will tend to mitigate



Wodehouse 12914

such outlays. The position has not significantly changed since we made our original recommendations.

9. Our appraisal of the whole field of health services revealed two special areas where progress has lagged and which, in our view, require over-haul with a view to fundamental reform in one instance and building from current inadequacy in the other.

These two special areas are the mental health and the rehabilitation services and we recommended that their needs required attention in the third priority. The most recent pertinent development is the decision of the Canadian Council on Hospital Accreditation to conduct a pilot survey of ten representative mental hospitals in Eastern Canada with a view to the eventual extension of the accreditation program to mental hospitals.

10. Medical Services Insurance was presented in The Canadian Medical Association submission as occupying fourth priority in order of need and importance. The preoccupation with methods of budgeting for personal health services which has characterized many submissions suggests to us that too narrow a view has been taken by many people. In so saying we do not deny that prepayment for medical services is important but methods and devices are not lacking in Canada and their services are continuously being improved.

11. During the past few months public attention has been focused on the subject of Medical Services Insurance, during the dispute between the Government of Saskatchewan and the profession in that province and, to a lesser degree, during the recent



such matters. The position has been consistently
changed since we made our original recommendations.
The application of the whole field

process has lagged and while, in a very real sense,
but with a view to the future, it is not possible
and coming from various institutions, a new order
these two sectors should be considered as one and the
realization services and we recommend that they
be made more and attention in the future. The
most recent results have been very satisfactory in the

prior survey, of a very small number of cases, in
Eastern Canada, with a view to the general situation of
the sector, but in general, the results are satisfactory.

It is also necessary to consider the
presented in the Canadian Council on Social Development
as occupying fourth place in the order of need and importance.
The present situation with regard to the sector of
personal health services, which has been characterized since
the 1960s, appears to us that the sector is viewed as
being taken on many points. It is not always so, but it is
that organizations for medical services are important but
methods are devised and the sector is viewed as important and
services are considered, being included.

It is during the past few months public
attention has been focused on the subject of medical
services insurance, during the dispute between the
Government of Saskatchewan and the profession in the
province, and a number of other factors have been



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Federal election campaign. In both instances politicians and aspirants to political office -- from one party -- tried to use a political ideology to rationalize a complete take-over of medical services insurance by the Government. The results in both instances suggest to us that the people of Canada are not anxious to place medical services under political control. The outcome does not suggest that health insurance under government auspices as a matter of public and political policy is overwhelming in popular appeal. Our assessment of insurance for personal health services as fourth in priority represents its place with reasonable accuracy. It does demonstrate, however, that it is possible for a very vocal, organized minority to produce the impression that the majority of people in this country want a compulsory universal health program.

12. Programs which merely alter the method of payment, which divert the financing of personal health care from private to official agencies or transfer control to the hands of government do not recommend themselves to us as progressive solutions to a complex problem. The recent events in the province of Saskatchewan are illustrative of the consequences which follow legislative efforts to acquire control of medical practice and its practitioners by controlling their financial affairs. It is clear that the legislation is now recognized as having been coercive and the amendments passed at the Special Session of the Legislature on August 2 are designed to correct the outstanding defects.

13. The agreement which ended the impasse in



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Saskatchewan was a compromise. Neither the doctors of Saskatchewan nor the doctors of Canada would support this compromise as an effective answer to the basic problem. The current Saskatchewan program contains a number of features which the medical profession opposes:

a). Compulsory participation for all citizens is an undue limitation of the rights of the public and is in our opinion unnecessary.

b). The existence of a government administrative commission with powers which supersede those of the approved agencies minimizes the effectiveness of those agencies and has drastically reduced the number of competing insuring programs.

c). The power of the administrative commission to set conditions of payment and practice for some doctors can adversely affect other doctors, even those who choose to work outside the act.

d). The government decision to pay for the entire cost of medical services is in our opinion wrong. The financial control of medical practice, which is inherent in this decision, could easily be used to the detriment of medical standards.

14. We must conclude that we could not agree that the Saskatchewan solution is to be preferred over



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the available alternatives and we foresee the possibility that the allocation of such a large proportion of government revenue to Medical Services Insurance may adversely affect the provision of public funds for other essential health purposes.

15. In all provinces, government already has some participation, directly or indirectly, in the provision of prepayment for medical services, and events suggest that this role may be extended. We believe that in the many areas wherein the profession is cooperating with government, accord through consultation with constructive negotiation is essential to the attainments of high standards of health care for Canadians. However, we consider government intervention into the field of prepaid medical care to the point of becoming a monopolistic purchaser of medical services, to be a measure of civil conscription. We would urge this Royal Commission to support our view that, exclusive of states of emergency, civil conscription of any segment of the Canadian population is contrary to our democratic philosophy.

16. The alternative which we have proposed to this Royal Commission and which is here elaborated, is selective financial aid to the needy through taxation and the encouragement of the self-supporting elements of society to protect themselves through voluntary insurance.

17. We recognize that, although the majority of Canadians today have insurance protection in greater or less degree, some of our fellow citizens have not, either because they cannot afford the cost or because



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they are ineligible for enrolment. It is our endeavour to remove both of these barriers to Medical Services Insurance.

18. In our previous submission we categorized the persons requiring assistance to purchase comprehensive medical services insurance as, 8% of the population so low in the economic scale that they need the provision of the complete cost, including the cost of prescribed drugs, and a further 16% of the population requiring partial aid. We assumed that the latter group, some of whom are now provided with insurance through their contract of employment, would consist of half requiring a two-third subsidy and the remainder a one-third subsidy. We are well aware that the identification of persons requiring such aid from public funds involves a process of selection, that members of the groups will experience changes in their economic status and that the application of a means test will be necessary. This device has been described as humiliating, administratively difficult and prohibitively expensive. We do not believe that the assessment of need deserves such condemnation and indeed we would point out that every public authority in the country now uses a means test to distinguish between the eligible and the ineligible for the award of public funds. Such testing procedures are perhaps best carried out in the home community of the applicant, provided that uniform criteria are applied, but we can provide evidence that in some instances a single provincial awarding authority administers a means test on a province-wide basis without



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undue procedural difficulty or expense.

19. We would re-state our conviction that selective aid is feasible, humanitarian, appropriate to the state of Canada's economic position, publicly acceptable and that it avoids the defects which we perceive in compulsory monopolistic plans applying to whole populations. It follows that it would be unnecessary to establish separate carriers for the proportion of people who would receive such aid and we suggest that the non-profit plans of prepaid medical care established and sponsored by the medical profession are available, experienced and worthy of administering the medical care insurance benefits. We have pointed out that in five provinces, agencies of the medical profession are now receiving public funds and administering programs of medical care to recipients of public assistance. The extension here proposed is one of degree rather than kind.

20. It has been characteristic of the development of medical care insurance that group enrolment, preferably the employees of a common employer, has formed the basis of coverage. It is unnecessary to elaborate on the advantages of such arrangements from the viewpoint of subscriber and carrier but it has the basic defect of leaving uncovered many persons who do not qualify for group membership. The enrolment of very small groups and individual subscribers has been approached with caution because of the hazards of adverse selection but it is now recognized that voluntary carriers will not fulfil their function until their



benefits become available to all who desire to purchase them. Experiments in community enrolment have demonstrated that it is feasible to accept all members of a community regardless of group status, age or state of health and from here it is not a prodigious step to the coverage of individual applicants of any age. This step has been taken by doctor-sponsored plans in Alberta, Manitoba and Windsor, Ontario, where individuals of all ages and physical condition may enrol at any time for comprehensive contracts. In other areas the problems of adverse selection are more acute but individual coverage is being made available through the use of "timed" enrolment periods. In the four Atlantic provinces open enrolment in a comprehensive coverage is being offered for the first time between September 1 and 20. In Ontario an Insurance Company has twice, within recent months, made available to all persons for limited time periods enrolment in a reasonably comprehensive program. Last May in Quebec open enrolment was offered during a three-week period in a contract which covers medical services provided in hospital. We anticipate that all these organizations will provide additional opportunities for individual enrolment.

I might add, sir, that I had a personal communication from Mr. Stiver that effective January 1st, 1963, their in-hospital contract will be available to all persons regardless of age, state of health, et cetera.

THE CHAIRMAN: That is for the Province of Ontario?

DR. WODEHOUSE: Yes; that is in-hospital.

21. In the one remaining province, British Columbia, the age distribution of the population poses unusual problems. We all recognize the increasing cost of providing coverage for older persons and in British Columbia the medical profession, the prepayment plans and



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1
2 the insurance industry have been carrying on dis-
3 cussions with a view to providing on a cooperative basis
4 a comprehensive coverage for the aged and the uninsurable
5 at a reasonable premium. We are hopeful that a solution
6 will be found and that a comprehensive individual cover-
7 age will be available in British Columbia within the next
8 few months.

9 22. The C.M.A. favours variety in the type
10 of insurance coverage available. We believe that the
11 peaceful co-existence of service, indemnity, and reim-
12 bursement methods has contributed to quality in coverage,
13 to reasonable premiums as well as reserving the
14 essential right of choice for the public. A refund
15 arrangement, based on the Australian method, may soon
16 be introduced in one province in Canada, that is British
Columbia. We would like to see further experimentation in
types of coverage.

17 23. We are pleased the representatives of
18 Trans-Canada Medical Plans and the insurance industry
19 have been sitting down with us to discuss ways of
20 extending medical services coverage to the so-called
21 uninsurables and to the older age groups. Various
22 methods have been suggested. The Canadian Health
23 Insurance Association has already presented to this
24 Commission its proposal for the pooling of high risk
25 persons. This is one possible solution which in a
26 modified form may meet the problem presented in some of
27 our provinces. Alternatively, representatives of our
28 prepaid plans have suggested the use of public funds to
29 reduce the net premium costs of the high risk groups to
30 that of the general working population. This is a pro-
blem which needs further study before we can decide
which is the best approach. We mention it here to show



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that we are aware of the problems of our system as well as the benefits which it provides. We are hopeful that the continued cooperation of all providers of insurance and prepayment will enable us to find a satisfactory solution within the voluntary system so that we can make available to all a comprehensive coverage at a reasonable premium cost.

24. The word "comprehensive" has been used in many discussions before this Royal Commission and we are sure that you understand that in the profession-sponsored prepaid plans it means payment for the services of participating physicians rendered in home, office or hospital. In the early days of prepayment experience, exclusions and waiting periods for benefits were common but these are gradually being eliminated. The Committee on Prepaid Medical Care of The Canadian Medical Association has recently recommended to T.C.M.P. member plans that if their basic comprehensive contracts do not already include them, the following benefits be made available:

Laboratory services without dollar limitation
X-Ray benefits without dollar limitation
Periodic health examinations
Psychiatric care
Well baby care
Refractions when performed by a physician
Treatment of alcoholism and drug addiction.



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The other essential health services, ordered by the physician but not provided by him fall into the category of Extended Health Benefits.

25. It will be observed that the medical profession and its sponsored plans are making progress in removing all barriers to the availability of voluntary medical services insurance and we recommend this method of extending benefits to every Canadian who desires such protection. Incidentally, I might mention that the extended health benefits are available under doctor-sponsored plans.

26. The health services which relate directly to the Government of Canada or which are financed in any degree from Federal funds were considered in some detail and the proposals for their improvement which emerged were grouped in our fifth priority classification. Among the areas where improvements were recommended were: Indian and Northern Health Services; the services provided through the Food and Drug Directorate; four upward adjustments under the National Health Grants program; certain legislative changes in the Hospital Insurance and Diagnostic Services Act; and a review and re-assessment of the functions of the Treatment Services under the Department of Veteran's Affairs. In the interval the full extent of the teratogenic effects of thalidomide have become evident and this unfortunate incident adds weight to the recommendation that better methods of testing new drugs before licensing for sale in Canada are necessary. We repeat the summary and recommendation made to this Commission in May:

"We recommend that the authority, the staff, the facilities and the budget of



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the Food and Drug Directorate be amplified to provide for:

- a) The control of quality, potency and safety of all drugs offered for sale in Canada.
- b) An authoritative information service on all new drugs.
- c) Ways and means to facilitate clinical trials of new pharmaceutical products."

In sixth and last priority we grouped certain miscellaneous recommendations which arose incidentally to our far-ranging examination of the health services. These included proposals for:

- a) Specific assistance to research in alcoholism, in the medical aspects of traffic accidents and in the medical phases of the process of rehabilitation.
- b) Subsidy from public funds to attract a doctor to areas otherwise unable to support a physician.
- c) The Income Tax deductibility of the expenses of attendance at refresher courses by practising physicians.
- d) Appropriate amendments to the Criminal Code to restrain the drinking driver, and increased educational efforts directed towards the prevention of accidents, particularly traffic accidents.

It appears to us that with all the views



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presented to the Royal Commission on Health Services at the public hearings your task is just now approaching the important stage where selection, rejection and coordination will demand your utmost wisdom and intelligence and the correlation of your findings with those of the research studies which are still proceeding remains to be undertaken. We appreciate the importance and the difficulty of your assignment but we also recognize that your report and recommendations are likely to chart the course for the future development of health services in this country. This is a challenging objective which justifies all your efforts and, as the instigators of the study, we feel a continuing responsibility, and The Canadian Medical Association renews the offer previously made to render all aid to make your investigations abundantly productive.

THE CHAIRMAN: Thank you very much Dr. Wodehouse. Now do any of the gentlemen who are with you wish to add anything to what has been said or have you any comments to make on the submission made here today? This is the last time you come to bat.

DR. RABSON: There have been several comments made about the limitations of plans suggested to you other than complete state controlled plans. These have had to do with mobility and comprehensiveness and waiting periods.

I should like to point out that the only example that we have of a state run plan has not removed these disabilities. You go to the Province of



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Saskatchewan, if you move there you have to wait three months before you are eligible for benefits. Furthermore, within the plan itself they have not eliminated one thing that we have been told was going to be eliminated, that is the second class citizen. You still have the doctors and the Government working in co-operation on a plan on the indigents, the welfare groups, where the doctors contribute forty per cent of their services free. That plan has not been taken over by the Saskatchewan Medical Care Act at present. Therefore the objections that have been raised about voluntary methods in this regard are not valid sir.

THE CHAIRMAN: Is there anyone that would like to make any comment?

DR. WODEHOUSE: I think I have to say something about the remarks of our associates in the chiropractic profession this morning who seemed to take a rather hard view of some of our feelings. I remind you of the sequence of events which led to the Noble Report being made available to you.

Following one or two questions from the Commission, I was asked if I was aware of any study which had been carried out by any of our associates concerning chiropractic and osteopathic profession and I said yes, such a study had been made at the request of our College of Physicians and Surgeons in Ontario a few years previously and I thought copies would still be available.

At your request sir a copy was forwarded to you.

DR. RABSON: May I say something to that?



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I would like to say something to Commissioner Firestone in regard to what he termed restrictions by the medical profession on the services of chiropractors. I would like to state sir within our own profession there are many restrictions on what a man can do and cannot do in hospitals, and our stand - I do not know whether it is an official stand, but I believe our stand to be official in many parts of Canada is that if this group of practitioners could gain university recognition, that we would prepared to recognize them as a profession.

We have not said, and the medical profession has had no authority to say that these people cannot practice chiropractic. We have just said that they have failed to fulfill what almost every other profession has had to fulfill, the requirements for a university degree. If a university can be found to do that, that will be acceptable. I believe the suggestion you made sir is the right one, the basic science, and the basic training is parallel. They can then go off to their own branch and be very good orthopedic surgeons.

DR. WODEHOUSE: I think sir it is probably the interpretation of the phrase which you quoted a few times, elevate them to extinction. It is our feeling if one elevated the training of these healing sciences to that given in our medical schools, that all of those people would see the preference in our method of treating the ill and most of them, as one of the representatives this morning almost said, would have followed the medical teaching rather than the chiropractic as an end result and this sir I think is a



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fair objection. This point has happened.

I think you asked the question about the States which permitted osteopaths to operate in hospitals, and have hospital facilities. This has happened in California and I think also in Michigan. The standards of education of the osteopathic schools have so paralleled those of medical schools, the end result has been almost indistinguishable.

I have no objection to such people who are well trained having full privileges. We do feel that it is a mistake to have people dealing with ailments of the human body when they deal with, as we were told this morning, structural disabilities and are unable to recognize pathology. We feel the training in pathology and other allied basic sciences is important as a protection to the public.

I would remind you sir that the Colleges of Physicians and Surgeons which operate across this country are actually extensions of government and they have entrusted to them by Government the standards of medical treatment, medical education available to the people within those provinces and it is in the discharge of that capacity, in that responsibility where our Colleges have encountered this difficulty with some of the other healing arts.

THE CHAIRMAN: On page 1, the start of paragraph 4, what you read here this afternoon Dr. Wodehouse. You say:

"We believe it is obvious that the sole control of finances of health and medical



I think, on the whole, the position about

hospitals, and more especially, I think, the
hospitals of the Government and the hospitals of the
State, is a very important one. It is one of the
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The position is, I think, that the
country is in a very important position.



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services by any single body, be it governmental or otherwise, implies the distinct possibility of complete control of the standard of health care and medical practice."

Would this eliminate, in your view, a province that might choose to have a body such as P.S.I. to be the media for the collection and payment of medical accounts?

DR. WODEHOUSE: Sir if it were the sole collector and administrator and payor of medical accounts, yes, I would say it would eliminate P.S.I. or any other single agency or organization.

We are well aware, from our own personal experience, of control of our own plans. We see that. We support them. We sponsor them. We are well aware of the administrative grip, the stranglehold which they ultimately come to have on those practitioners whose sole source of income comes from that organization.

THE CHAIRMAN: So in your view, I accept from that, that you are opposed in principle to what Premier Duff Roblin suggested in Manitoba, using Manitoba medical as the vehicle for the collection and payment of the physicians' accounts?

DR. RABSON: I believe our brief in Manitoba made that clear.

THE CHAIRMAN: I do not know that I saw it making it quite that clear. I thought you really opposed the idea of them subsidizing the premium, that aspect of it, but not the use of the Manitoba Medical



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as the administrative vehicle.

DR. RABSON: I believe sir that in our supplementary brief we distinctly said that we approve of the multiplicity of carriers.

THE CHAIRMAN: That is quite true. Now we may all be in favour of multiplicity. Does it bring us to what you are saying? You are saying you are opposed to one form of carrier or vehicle, whether governmental or otherwise.

DR. RABSON: The answer to that is yes. I do not believe sir that we have been able to find the best method. I think we have said this before, no one knows the best method of providing health service. I do not think we have found a method within the ability of anyone who can control the finances without controlling the practice of medicine, and all other health services. I think the Hospital Services Diagnostic Act in this field has demonstrated this.

THE CHAIRMAN: What would be the minimum number of vehicles that you could say would meet your wishes, or would come out from under your condemnation?

DR. RABSON: I am not sure that the number of carriers is particularly important. It is the method whereby the doctor or the health worker is paid. For instance, if you had a refund system, or reimbursement system. By "refund" I mean the patient receives his money from a source, or if he presents a receipted bill, I call that reimbursement, that type of system would allow the doctor to deal with his patient. Under that

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type of system the number of carriers is not so important.

THE CHAIRMAN: Even one would be all right there?

DR. WODEHOUSE: I would have to disagree with that.

THE CHAIRMAN: I saw three heads all moving in a different direction.

DR. FREAMO: I think sir the basic problem in this whole field is the profession, as well as many other organizations, is trying to find the best method of providing insurance to insure the future safeguard of the practice of medicine.

Now I might say that many of us felt that the privilege to work outside a plan or outside an Act, on a refund basis with patients, was sufficient to protect medicine in that the doctor, in his relationship with his patient was not controlled. We find sir, in the Saskatchewan situation that this was not really true. So long as the agency existed it could indirectly control you, or indirectly affect you, even though you had no official relationship with that agency. Now we have had to realize that our original thinking was fallacious and we are re-examining the relationship which should necessarily exist.

I do not think sir we can tell you exactly how many, in terms of plans, what we call a multiplicity is desirable. Our concern is that there should be a number of methods. That is, that we should have a service, we should have what you might call unemployment insurance or an indemnity method. We are



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frankly more interested in what we call refund under this Australian type of program.

THE CHAIRMAN: And the Swedish.

MR. FREAMO: And the Swedish. That is refund, as well. We feel if each of these sir can continue to operate that by their very existence, each one will affect the other, and we might find one which is the answer. That is perhaps the millennium to hope for but we really at the moment have not found that any single device, that we know of at the moment, really provides all we want to see in insurance measures.

THE CHAIRMAN: Now then you carry on at the foot of the page by saying:

"For example, under the Hospital Insurance and Diagnostic Services Act there is evidence that government agencies go beyond their intended purpose and soon become sources of coercive regulations from which there is no appeal."

I assume you are in a position to give us examples?

DR. RABSON: I believe sir the President of the Canadian Hospital Association made this statement, that the Government had passed the hospitalization bill.

THE CHAIRMAN: Is that the source of your statement?

DR. RABSON: No, that is not the only source. My point is on the budgetary restrictions, there is no appeal against them. Once the Commission in various Provinces says this is the amount for this

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For example, in one Province, the Hospital Commission will not pay anybody other than a radiologist for reading an x-ray. With the shortage of radiologists, of which I am sure you are well aware, this becomes a problem. There were arrangements between the local hospital and the local doctor where he would read the x-rays on in-patient factors, and so forth. Now either doctor does it for his own, separately. This is proper and he does this, but the hospital can find no money with which to reimburse this man and in many of the x-rays the services of radiologists are not essential, other than the truly complicated diagnostic procedures. That is one example of laws against which there is no appeal. We have appealed this frequently.

DR. McMILLAN: May I give you two examples? One in our Province is this, and Miss Girard would be very interested in this. The Commission ruled that during the holiday season no replacements for those persons on holidays are available, and we have to go short staffed during the holiday period. This even includes the operating room nurse. This is the measure of restriction we feel is unjustified and impractical.

The second one which perhaps the medical know, and is a little more noticeable, this is the example of a woman who went to the hospital because she had a cancer of the breast. This was a very late and inoperable type of thing, and in consultation with my confreres we decided that surgery perhaps in this instance would not indicate it but perhaps deep therapy

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We arranged this. We found out she was eligible for hospital care under the hospital commission so we treated her surgically and I took the breast off but if we treated her with deep therapy, she was not eligible for hospitalization. We tried to discharge her and she was unable to find a place to live in the town.

When I asked the Commission, they said all we can do is let her go home. It so happened later we were able to get a place for her to stay. This is an example of where a certain amount of pressure for the form of treatment is indicated by the regulations of the Commission. It may not have been intended, but it was there in any event.

DR. RABSON: I would like to say something I think is important and that is, as Dr. Wodehouse has said, we have recognized that these are under a plan or an agency or administrator who wants to control the type of thing that a doctor wants and believes should be done for a patient and which are, in the opinion of others, good medical practice, but because the administrator feels that this may either cost too much or may not be necessary, it is not done. These things are hard to restrict so that our criticism does not only apply to the Hospital Services Diagnostic Act. It applies to our own sponsored plans where we have seen this danger develop.

DR. WODEHOUSE: I want to say something about the payment for radiology and laboratory technician



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DR. BARBOUR: I would like to say

something I think is important and that is, as Dr. Wodehouse has said, we have recognized that there are under a plan or an agency or administrator who wants to control the type of thing that a doctor wants and believes should be done for a patient and which are, in the opinion of others, good medical practice, but because the administrator feels that this may either cost too much or may not be necessary, it is not done. These things are hard to restrict so that our criticism does not only apply to the Hospital Services Diagnostic Act. It applies to our own sponsored plans where we have seen this danger develop.

DR. WODEHOUSE: I want to say something

about the payment for radiology and laboratory technician



Wodehouse 12935

training. In my Province there is a standard flat rate set down for each year, so much per month. This is the same rate irregardless if you have an office in Sudbury, in Toronto, or in Windsor.

Without casting a reflection on any of those centres, there are certain centres which are more popular than others. The less popular centres, therefore, have more trouble obtaining people to fulfill these posts which do carry with it some service to the institution while they are undergoing training and the final result is a lack of personnel. There is no leeway given for local variation in that matter.

One other item from a matter of Hospital Services and Diagnostic Services Act, the matter of people switching from one Province to another. I think I have mentioned this before. This applies to people coming to Ontario from other Provinces. I am thinking of the university student level where we have people coming from all Provinces of Canada. There is no way I can assure any individual student from any individual Province, outside of Ontario, that his hospitalization will be permitted to be continued while he is training in school in Ontario.

I have to write to each of these individuals telling him that if they wish to continue hospitalization coverage, which we recommend because it is very expensive in Toronto, they ascertain from their own individual Province whether or not in their individual case their insurance will be carried through, and if not, then they must apply as soon as they get to Toronto



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Wodehouse 12936

in order to cover themselves. There is a three month waiting period but they have a three month carry-over from the other Provinces. It is a matter of them applying the day they arrive in Toronto. Otherwise, they will have a gap in their insurance coverage. Under Blue Cross this is quite feasible, under the voluntary system. All you did was take up residence in the new hospital, pay a premium in a new office. Under the governmental plan, it is not possible.

THE CHAIRMAN: I want to know about another matter. This matter of covering everyone regardless of age or condition. You refer to it on page 7. You say:

"Experiments in community enrolment have demonstrated that it is feasible to accept all members of a community regardless of group status, age or state of health and from here it is not a prodigious step to the coverage of individual applicants of any age. This step has been taken by doctor-sponsored plans in Alberta, Manitoba and Windsor, Ontario, where individuals of all ages and physical condition may enroll at any time for comprehensive contracts."

Now I will limit my question to Manitoba. This is a change from when we were in Winnipeg in January.

DR. RABSON: In order to keep the record clear sir this matter was studied for two years



Wodehouse 12936

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before it was put into effect. It was put into effect in January, 1962.

THE CHAIRMAN: Are you in a position to say whether or not, have you had sufficient experience with it to determine whether there is any great increase in the cost of the operation of that program from the acceptance of risks of any age or any condition?

DR. RABSON: I do not think we are sir. The first period of six months is being studied. I do not think we have the figures as yet. I do not think there is any doubt the costs are going to go up but we hope that they will be absorbed by all the people enrolled in the plan.

THE CHAIRMAN: As you know, our Dr. Berry made a very detailed study of the operation of the program in Manitoba. I was wondering if there is anything now which might be made use of in this regard?

DR. RABSON: We have set up our own study Committee sir. They started work on January 1st to study the second sixth-month period.

We hope to have that report ready by the end of March; if it would be of any use to you then.

THE CHAIRMAN: I do not assume that we will have amassed all knowledge by March.

DR. WODEHOUSE: I notice you have limited your question to Manitoba.

THE CHAIRMAN: It was because of the special study that we made of the figures.

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Rabson 12938

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THE CHAIRMAN: And the co-operation that we got.

DR. WODEHOUSE: May I point out a difference in the situation between Manitoba and Ontario. In Ontario where you have many large urban centres, where there is a high degree of industrial employment, and so on, many of our industrial firms have provided health insurance coverage up to the age of retirement and in many instances the individuals at the age of retirement have the option of carrying on that pre-existing coverage but at their own expense.

Now if we adopt the Manitoba plan and threw it open to individual coverage in Ontario, to all individuals, we would expect to pick up most of the people who retired at age 65. It would overload our prepaid plan excessively and adversely.

THE CHAIRMAN: That is what we want to know, whether it will overload it. Whether it will increase the cost so much. We were told in New York of this sample of some ten thousand at H.I.P. were taking on these people and they were surprised with the small effect it had on the cost factor.

DR. McMILLAN: If you have individuals at all ages it is different from taking a whole group and giving them one coverage.

THE CHAIRMAN: It was a case of taking ten thousand over sixty-five.

DR. McMILLAN: If they are pooled with other individuals it makes a difference in the overall



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McMillan 12939

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THE CHAIRMAN: We are only talking of putting them in with everybody.

DR. McMILLAN: Under our plan we might have a fellow for fifteen years, from fifty to sixty-five. We might carry him through to sixty-five, but it is not as costly as perhaps picking him up at sixty-five.

THE CHAIRMAN: All we can suggest to you gentlemen is that the program that does not cover everybody at every age and every condition is going to be deficient.

DR. WODEHOUSE: May I complete my remarks? I mentioned this difficulty only to acquaint you of the fact that we are aware of some defects in our present system. I might say we have engaged in conversation with our C.H.I. confreres through the year in an attempt to resolve these things.

We also might say we have been accused many times of putting ourselves into bankruptcy by extending our coverage. We still extended it.

I think extending it without age limits is another step, and I would expect that in the future years we will extend it to the total population.

THE CHAIRMAN: The reason we have to put this to you for such reply as you wish to give, and you are able to give, is that it is being represented to us by others, and by organizations that have taken a great deal of time to study and go into these matters, such as the next submission that we are going to hear this afternoon, they say that the only way that you can



McMillan 12339

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Freamo 12940

cover everybody of all ages and regardless of pre-existing conditions is through the type of program that they advocate and which you say is inadequate to you. The country at some stage may have to make a decision on that issue.

MR. FREAMO: We appreciate this. We are very concerned about this problem. The little experience that we have had with people over the age of sixty-five, and particularly with new applicants for enrolment from these people is that the first year you take them on, you have relatively good experience but that your experience is inclined to worsen somewhat with time.

Now this has, to a degree, been the Alberta experience with this over sixty-five group. I do not think we should try to minimize the problem, as we see it of asking our own prepaid plans to assume an extraordinarily large number of persons who have attained age sixty-five, merely because their insurance or indemnity has been cut off from their existing employer.

We feel from discussions with prepaid plans, and with the C.H.I.A., we can resolve this. We do not necessarily agree with each and every thing that the Health Insurance Association people said today, but I think it is fair to say that on the 1st of January, or very close to that date, we are going to have something of this sort in existence in British Columbia and that it will be on the basis, we think, of co-operative effort between the commercial insurers and our prepaid plans. It is going to go in all our prepaid plans anyway, but



12040 Treas

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Freamo

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we know this is a problem and one that we have to tackle.

We feel in this area that we are better to enter into it on a co-operative basis so that we will not have this unusually heavy entry at the age of sixty-five, or thereabouts, through retirees. We are very aware of it sir and are doing our best to overcome it.

THE CHAIRMAN: We put the question to you gentlemen representing the Canadian Medical Association: What program does the Canadian Medical Association say should be adopted that will give coverage to everybody of all ages and all pre-existing conditions?

Now you have told us the things that you say you do not approve of. I would like to get the opposite view. What is the answer of C.M.A. to that question which we feel is the whole problem?

DR. WODEHOUSE: I think a short answer, which is an unsatisfactory one from your point of view, I recognize, is evolution. We are getting there. We are getting there progressively and I think our system, as we have advocated here of partial assistance to the low income group will take in a fair portion of our elderly citizens. We will attain a very fair coverage of people.

Now it is not our aim to compel everyone to have insurance. We have stressed and we do stress again that it should be available to them and we think that the method we advocate will be best. There are many other methods which can be worked out, and I was interested in your crediting the point of view to our friends, the Labour Congress, where they feel there is



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Wodehouse

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only one way of doing it. There are many ways of doing almost everything. It is a mistake to adopt a new one or of doing something new until you are sure what you are doing is an improvement, but one of the methods which could be brought into cover the over sixty-five people is to provide a subsidy for those over sixty-five.

Many of our colleagues feel this is a desirable thing but there are many others who feel this is opening the door to everybody. This area is under discussion in our own council and we have not got an opinion on it as yet. Essentially we are not in favour of it. We are still thinking of it, and that is a method which would cover the older aged person and reduce the premium of the younger people and permit the insurance to be sold at pretty reasonable rates.

DR. RABSON: I do not think our answer is so unsatisfactory. Our answer is nobody knows the best way to do this and these gentlemen who are going to follow us have made public claims in 57 countries for National Health Services and you are aware that none of them is the same. All are different and they vary from the voluntary to the complete compulsion and our answer is that everybody should be able to buy what he wants to buy or can afford to buy and those that cannot afford to buy will get state health. It is this insistence on the one plan that worries us because we feel very strongly, and we have evidence to back this up, I think, that if the financing of a total plan is undertaken, the very thing that should be done in the health field - housing, I believe, is a perfect example. In this



Wodehouse

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Rabson 12943

country I believe it has been shown that over one million housing units are needy and there are only eleven thousand that have been built under our renewal system.

Our fear is that if you take this Government taxation money and put it all in this one plan, without the individual contributing a premium, without the individual looking after himself, you are neglecting this important fundamental area of health care.

We do not believe there is any one best answer to this thing outside of the fact that the people who need health care should get it.

This is another case where we can use Saskatchewan. This is one Province where going into a hospital can still cost you a lot of money through the drugs that are excluded from coverage.

In the Province where I come from all your costs are covered and in the hospital in this Province, which pretends to want to apply all the care coverage of the people, the total drug bill is not covered, and this is a sort of thing we are afraid of if you have the one plan, or come up with the one answer.

We do not think there is one answer.

THE CHAIRMAN: Thank you.

COMMISSIONER FIRESTONE: Dr. Wodehouse and gentlemen, I found your Supplementary Submission very helpful; you have come forward with new ideas and new suggestions which are indicative of the progressive attitude taken by the Canadian Medical Association, and I compliment you in doing so.

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Wodehouse 12944

I would like to follow up one point the Chairman made on paragraph 4, page 1, in which you say that the welfare of patients can be affected adversely where there is only one source of funds for the payment of such services; and then you go on to refer to the Hospital Insurance and Diagnostic Services Act, and then end up by saying "regulations which from there is no appeal."

Now, assuming there were an adequate appeal procedure, would you be satisfied?

DR. WODEHOUSE: That is a very broad question, Commissioner Firestone. I would say it would be an improvement. I do not know the details of what you have in mind, but it would be an improvement.

COMMISSISONER FIRESTONE: I am referring this sentence about the Hospital Insurance and Diagnostic Services Act to the previous statement you made in paragraph 4 in which you say: "that the sole control of finances of health and medical services by any single body, be it governmental or otherwise, implies the distinct possibility of complete control of the standard of health care and medical practice."

Now, if there were an appeal procedure that would be adequate in the opinion of the medical profession, would it necessarily mean that the quality of care would be adversely affected?

DR. WODEHOUSE: I go back to this one question of finances, and I do not want to get into the political field too much, but I want to remind you of the events of the last few months where the civil



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Wodehouse 12945

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5 because of the economy of the country and another group
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7 far as I know, there is no appeal in that thing. But
8 this is the type of thing we feel that would apply not
9 necessarily only to doctors but also to all services
10 looking after patients. Four provinces, the Provinces
11 of Saskatchewan, New Brunswick and two others, have
12 frozen it, and surely this is a restriction. This is
13 a case of deciding, as one of our pathologists quoted
14 to me, between a pot of paint for the walls or a new
piece of technical equipment.

15 This morning you asked the lady if
16 she had noticed any change in the quality of care she
17 received in Saskatchewan. I would be very surprised
18 if she had noticed it, but I wonder if she would notice
19 any change in the quality of medical care in ten years
20 from now, twenty years from now, when you have produced
21 a political climate which will now affect the quality,
22 and we know in the long run the quality of control will
suffer.

23 DR. RABSON: It is this source of funds
24 which leads to control, with an agency which we ourselves
25 have created.

26 In the Province of Manitoba the Minister
27 of Education has made the decision that a teacher with
28 Grade XI education and one year's teacher's college
29 training can teach grades up to Grade XI. Now, that
30 is exactly the sort of thing that the sole control of
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12945 12945

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Wodehouse 12946

COMMISSIONER FIRESTONE: But in order to safeguard against the misuse of any system you need an appeals procedure. Do not you think the medical profession and the government could work out a satisfactory appeals procedure?

DR. WODEHOUSE: I believe it could be worked out. I do not believe it would be very effective unless it is an appeal board. But appeals procedure would be very desirable in all these things.

COMMISSIONER FIRESTONE: I am turning now to page 4, paragraph 11, in which you refer to the Saskatchewan situation, and then you say:

"It does demonstrate, however, that it is possible for a very vocal, organized minority to produce the impression that the majority of people in this country want a compulsory universal health program."

Now, the question as to whether a province should or should not have a compulsory universal health care program is one that, presumably, governments will have to decide in their best judgement of what public opinion and public support of such a plan or proposal is. Now, assuming that governments in their wisdom decided that such plans are supported by the majority of people in the province, would you think that the medical profession would co-operate with the government in developing such a plan?

DR. WODEHOUSE: Sir, we are willing to sit down and discuss and negotiate with anyone on any



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Wodehouse 12947

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4 aspect of health which may lead to improvement. That is
5 a blanket statement, but it is true. We have some
6 conversations with governmental departments from time to
7 time, and we have our own affairs which we work out in
8 co-operation. But we have a difficulty in dealing with
9 governments. Government carries legislative weight,
10 and you may sit down and discuss it with them ad infinitum
11 and you may not hear anything for months, and then you
12 will hear a piece of legislation passed by the party in
13 power. We requested that pathologists and bacteriologists,
14 professional people, should not be included in the benefits
15 under the Act, but that is not the way the Act was written;
16 they were included. They have the power to ignore
17 everything you have said, and it is a great fear. We
18 do not feel that way in most of our governmental business,
19 but if we could negotiate on an equal basis with govern-
20 ment, it would be a different matter.

21 COMMISSIONER FIRESTONE: Do you
22 realize that if such a plan has the support of the majority
23 of the people they possibly cannot negotiate the principle
24 of the implementation of the plan; what they can discuss
25 is the guidance of the medical profession to put the
26 principle into effect in order to make it effective and
27 efficient, to work out the best co-operation. After
28 all, you people are providing a very important service,
29 and we are all interested that you continue to provide
30 this important service. A provincial government has
to take the decision whether in their opinion the people
of the province wish to have such a program or not,
and having made that decision, they can meet with the



12847 Waddell

aspect of health which may lead to improvement. That is
a blanket statement, but it is true. We have some
conversations with governmental departments from time to
time, and we have our own affairs which we work out in
co-operation. But we have a difficulty in dealing with
governments. Government carries legislative weight,
and you may sit down and discuss it with them as individuals
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Wodehouse 12948

medical profession and work out some scheme. Is this something that is acceptable or not acceptable?

MR. WODEHOUSE: It is acceptable to a degree. We have the phrase in here: "civil conscription". We had this from our Australian colleagues which says that government may do anything but civil conscription.

We do not want to find ourselves at the end of our discussions with: This is the only way we are going to do it, this is the only way you are going to practice medicine, live, get paid, your sons. Once these things are in effect they are very difficult to modify.

DR. RABSON: May I call Professor Firestone's attention to the first four items in paragraph 2? Does Professor Firestone think that the government is capable of deciding what is the best medical care for the people? This is the point which worries us.

THE CHAIRMAN: Or this Commission.

DR. RABSON: That was implied. My point is that we ourselves, as you can see, have great difficulty in understanding all the complexities and backwaters of this terrifically large Province, and to say that people can understand and vote intelligently on a problem of this magnitude seems to me to be a denial of facts. If this were so, we would not fear public decision, but emotion can be created in this type of thing and people can be swayed. This is why we asked originally for this hearing; we hoped that this Commission and its findings would be so widely advertised the people



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Rabson 12949

would understand the problem.

COMMISSIONER FIRESTONE: I am going on the assumption that the political persons in charge, the government, have come to the conclusion in a particular province that there is a desire for a medical program, and they come to the medical profession and say: "You may have different views, but in our opinion the people of this province want such a program. Can we have your help?" What would your answer be?

DR. RABSON: We do not under estimate the intelligence of the Canadian people, but do the Canadian people vote on the type of defence we have? This is the type of thing we would like to see set up in the health program.

DR. WODEHOUSE: If anyone wanted to sit down and discuss these things, we would be very happy --

THE CHAIRMAN: That is not the question Dr. Firestone has postulated, socialized medicine in a province.

COMMISSIONER FIRESTONE: I did not use the word "socialized".

THE CHAIRMAN: I am just interpreting your question. If a province chooses whatever plan it wishes to make, that having made the decision, it then goes to the medical profession.

DR. QUINTIN: Mr. Chairman, may I ask Commissioner Firestone if he was distinguishing this sort of thing from state medicine?

COMMISSIONER FIRESTONE: My question still relates to your paragraph 11 on page 4, where you say:



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COMMISSIONER FIRSTSTONE: I am going

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wishes to make, that having made the decision, it then

goes to the medical profession.

MR. CHURCH: Mr. Chairman, may I ask

Commissioner Firststone if he was distinguishing this

sort of thing from state medicine?

COMMISSIONER FIRSTSTONE: My question



McMillan 12950

"...the majority of people in this country want a compulsory universal health program." This is taking out of its context. I want to make it quite clear. I am basing my question on the phrase you have used in this paragraph, and my question is: Assuming that the government in a province comes to the conclusion that the majority of people do support, I am using your phrase, a compulsory universal health program in that province, and they come to the medical profession and they say: "We have come to this conclusion. Can you help us in developing such a program," what would the answer be?

DR. McMILLAN: The best answer is that in Newfoundland the Government did come to that conclusion with regard to people sixteen years of age and under, and the profession did sit down and work out a solution with the Government.

THE CHAIRMAN: So that the position is that the law enforcement agency has, for a good reason, decided something and they say: "We will sit down with you and decide what is the best way of doing this to you."

DR. McMILLAN: Does not that presuppose a crime?

DR. QUINTIN: Is not this the weakness of this argument by analogy, Mr. Chairman?

THE CHAIRMAN: Certainly.

DR. WODEHOUSE: I would have to certainly say I would sit down and see what is reasonable, but I would reserve the right of saying that what I think is not reasonable I would not co-operate in. I would re-



12020 Hamilton

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Wodehouse 12951

serve that right.

COMMISSIONER FIRESTONE: This is your privilege. But we are talking here not only of the Province of Saskatchewan, other provinces have taken that view, and if they happen to come into office presumably they would want to sit down with the medical profession. I would like to know, would they have the co-operation of the medical profession of sitting down and working out the best program possible?

DR. QUINTIN: I would say yes.

COMMISSIONER FIRESTONE: And they say that the majority of people support such a program and they come to the C.M.A. and they say: "This is the proposal. We want to do better than what these others offer." Would you sit down or say: "I am sorry, gentlemen, we would not sit down with you because we are against the principle"?

DR. QUINTIN: No, we would sit down with them.

COMMISSIONER FIRESTONE: You would discuss the question of a compulsory universal health program?

THE CHAIRMAN: The question is, if the government decided to have state medicine, Dr. Firestone is asking you, are you prepared to sit down and work out the details of state medicine with the government?

DR. RABSON: I think we should say that --

THE CHAIRMAN: Would you please apply yourself to that question? Answer it or do not answer it.



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DR. GUTHRIE: I would say yes.

COMMISSIONER FIRESTONE: And they say

that the majority of people support such a program and they come to the C.M.A. and they say: "This is the proposal. We want to do better than what these others offer. Would you sit down or say: 'I am sorry, gentlemen, we would not sit down with you because we are against the'?"

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Wodehouse 12952

DR. WODEHOUSE: I would have to speak for myself, because we do not seem to be in agreement with the interpretation of your question. But for myself, I would be very pleased to sit down and work out a program of insurance.

THE CHAIRMAN: That is not the question. The question is if the decision for state medicine --

COMMISSIONER FIRESTONE: I am using your phrase, a compulsory universal health program. The Chairman can put his own question.

DR. WODEHOUSE: I would say that they were wrong in their decision.

MR. FREAMO: The medical profession is willing to sit down with anybody, no matter what pre-conceived judgment that person has made, but because we are willing to sit down and discuss it with them does not mean that we are willing to accept a pre-conceived judgment they have made.

THE CHAIRMAN: Do you accept the question put to you does not leave you with any initiative?

MR. FREAMO: I would say this, that they have decided the issue beforehand and there is very little for us to do. Once it is decided there is going to be a completely compulsory program for everybody, the role of the medical profession in working out the details of this is minimal indeed.

THE CHAIRMAN: That is all Dr. Firestone was trying to bring out with you for the last fifteen minutes.

COMMISSIONER FIRESTONE: I understand



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for myself, because we do not seem to be in agreement with

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Quintin 12953

that the C.M.A. would sit down with the Federal Government to discuss the working out of such a program on the basis of the principle with the Federal Government. Now, you may, obviously, reserve the right that if the final outcome of these discussions is not to your satisfaction you will protest, and I think this is your right. But you will participate in the formulation of such a program.

DR. QUINTIN: Yes, that is right.

COMMISSIONER FIRESTONE: Thank you very much. That is a clear answer.

DR. WODEHOUSE: We would sit down and try to persuade them that they are wrong.

COMMISSIONER FIRESTONE: That, of course, is your privilege.

May I go to another question? You say in paragraph 13, you give in paragraph 13 four reasons why you think Saskatchewan's formula is not acceptable to the C.M.A. Am I correct in understanding that, that you do not approve of the Saskatchewan formula for the reasons stated in paragraph 13?

DR. QUINTIN: That is correct.

MR. FREAMO: Maybe there are particular parts of this, Mr. Chairman, that you wanted elaboration on, or all of them.

COMMISSIONER FIRESTONE: Well, my question is: If medical practitioners are permitted to operate outside a plan that may develop or outside an act or receive payments from private sources, why should they object to such a plan being developed if other medical



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Freamo 12954

practitioners wish to practice under it.

MR. FREAMO: Well, sir, I think I covered that earlier when I said that we did at one time think that it was a sufficient protection for the profession if they were allowed to remain completely outside an act or a plan, that they could then deal with their patients. But when the act in its implementation sets out administrative arrangements which mean that the doctor, whether he is working inside or outside the plan, can be affected by the working of the plan and can be affected adversely, then this itself is not sufficient protection for him.

For instance, in Saskatchewan, we are talking here in terms of what might be, because these are possibilities under the act. The commission which administers this may determine that a group of persons in a town want to obtain the services of a doctor who practices under the act and who will receive payments directly from the commission, and they may feel that, after all, this is made available to them and place a doctor in this small community. Now, they can pay this doctor a salary because you have any number of ways in which payment can be made. I, as a doctor living in some community outside the act, who has to earn my living where the other doctor does not have to worry because he is receiving a certain salary, I think it is only a period of time that will elapse before a sufficient amount of my practice will go over to him and before I leave the community. Even though I practice outside the act, the actions of that commission can affect me just as though



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Freamo 12955

I was working under it.

DR. RABSON: The question of practising outside the act is purely theoretical. There were doctors who refused to work under the M.M.S. in Manitoba, but it worked out that about seventy per cent of the people were under this plan, they had not much choice. When people see that seventy-two per cent is paid under the plan, I think you will have the people going to someone who is working under the plan.

DR. WODEHOUSE: I think paragraph 14 also contains a very important aspect of our objection to this, and this is our phrase: "and we foresee the possibility that the allocation of such a large proportion of government revenue to Medical Services Insurance may adversely affect the provision of public funds for other essential health purposes."

I would remind you, sir, that in the Thompson Report, which I understand was handed down within the last few weeks, eventually we have the recommendation with regard to mental health services and other health services with fairly astronomical sums of money, and it is our feeling that that amount of money will be a long time coming forward for these schemes.

COMMISSIONER FIRESTONE: I think this is fair comment, gentlemen. It may be quite proper to suggest that if a physician wished to practice outside the plan he ought to have certain safeguards to make sure this is not just a theoretical arrangement but a practical arrangement; and you do not have to accept the Saskatchewan agreement as the only and best formula. But can you



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P. 12955

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Rabson 12956

visualize a plan whereby some physicians will work under that plan and some outside the plan without those who wish to stay outside the plan feel that there is the element of control that you are speaking of?

DR. RABSON: If you have people who pay for health, you can have that kind of plan, and therefore people can work inside and outside the government at the same time.

COMMISSIONER FIRESTONE: You are mentioning people covered by the plan and people covered outside the plan, and my question is with regard to physicians working outside the plan and physicians working inside the plan.

DR. RABSON: Where we have a field of compulsory insurance I do not think we can help that.

MR. FREAMO: If we speak of the Saskatchewan ---

COMMISSIONER FIRESTONE: We are talking in general.

MR. FREAMO: I think there are three things that could be done in Saskatchewan which would make it acceptable to that particular Province. One is the elimination of the compulsory participation, because I believe and they believe that if you corner the market in anything you control it; once you have the compulsory aspect you will have control. Secondly, the administration could be, as part of its functions, the operation of insurance plans, which it in effect controls, and that it would not be for the Federal Government to hire doctors or decide the methods of employment, which is really one



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Freamo 12957

of the real problems in the present situation. The third is that the Government would not continue to try to pay one hundred per cent of the total medical bill, because we see long-term problems; one source of funds produced in the long term would produce disastrous results. I think if these elements were in it the profession in that Province would feel that the plan was a very good one.

COMMISSIONER FIRESTONE: Any other comments, gentlemen?

DR. QUINTIN: No.

COMMISSIONER FIRESTONE: May I turn to paragraph 22 on page 8, where you refer to the refund arrangement. I also recall earlier the mention of a reimbursement plan. What kind of refund arrangement do you have in mind? Is it a refund arrangement whereby a government would collect the funds and refund the patient or reimburse the patient on presentation of doctor bills?

DR. WODEHOUSE: I think Dr. Freamo is more familiar with that aspect.

MR. FREAMO: We have been particularly struck with the experience in Australia wherein patients pay the bill and then obtain a refund of some portion of the amount he pays from his insurance plan. This seems to control, to a degree, a trend in utilization which we have not been able to control as well under our system.

Therefore, the refund experiment we have in mind is a private plan, a private insurance arrangement wherein the patient would first pay his bill and would then, from the insurance plan, obtain a refund



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Freamo 12958

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COMMISSIONER FIRESTONE: Do I understand correctly Mr. Freamo that this is a refund plan sponsored by a group of commercial carriers, plus a non-profit organization?

MR. FREAMO: No sir. This is one of our non-profit plans in British Columbia. As indicated, it will be bringing this plan into being to look after its individuals and it is being brought into being purely on a trial basis so that we in Canada will have some knowledge of how the Australian method would work in Canada.

COMMISSIONER FIRESTONE: Is the Australian method one of a voluntary non-profit organization making the refund or the Government making the refund?

MR. FREAMO: It is the voluntary non-profit agency making a refund to their subscribers. In addition, they make a refund of a Government benefit as well as their own.

COMMISSIONER FIRESTONE: When you speak in this paragraph 22 that the refund arrangement based on the Australian method may soon be introduced in one province in Canada and you would like to see further experimentation of this type of coverage, do you have in mind a plan where Government would collect the premium, or taxes,



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Primo

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Freamo 12959

and use these funds to refund payment of medical bills either on their own or in conjunction with a non-profit organization?

MR. FREAMO: In this particular experiment the Government is not itself involved. It will be purely our prepaid plan. However, as in any other experiment if a Government was interested in doing it, we would be very interested in seeing it done as an experiment. They would, at least, in British Columbia.

DR. WODEHOUSE: Our point also, as put forward in our original submission in May, faced that very specifically and we recommended that Government relate its financial participation in the payment of physician services to those parts of the population in need, either a total need or a partial need.

The question you are asking sir is asking us to repute that statement, which was there several times. I do not think we can accept the implication there that such a refund system can apply to the population as a whole, without having a very serious review of our own internal policy.

We have had no such review, or reason to review it recently.

COMMISSIONER FIRESTONE: I am very glad you clarified this because in this sentence the last sentence in paragraph 22 you seem to favour some experimentation like the Australian method in Canada.

I take it such experiment would involve a Government financial participation on a refund basis?

DR. WODEHOUSE: No sir. This is an

and use these funds to refund payment of medical bills either on their own or in conjunction with a non-profit

MR. FRANK: In this particular experi-

ment the Government is not itself involved. It will be purely our prepaid plan. However, as in any other experiment if a Government was interested in doing it, we would be very interested in seeing it done as an experiment.

They would, at least, in British Columbia.

DR. WOODHOUSE: Our point also, as

put forward in our original submission in May, I need that

very specifically and we recommended that Government re- late its financial participation in the payment of physician services to these parts of the population in need, either

a total need or a partial need.

The question you are asking is asking us to refute that statement, which was there several times. I do not think we can accept the implication there that

such a refund system can apply to the population as a whole, without having a very serious review of our own

We have had no such review, or reason

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2 Wodehouse 12960

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4 experiment run by one of our own plans.

5 COMMISSIONER FIRESTONE: You say a refund
6 arrangement based on the Australian method. Now do I
7 take it from that, that you are not in favour of the
8 application of the Australian method to Canadian conditions?
9 If the answer is no, just say no.

10 DR. WODEHOUSE: If by that you mean the
11 interference by Government to the total population, no
12 sir, we are not in favour of that.

13 COMMISSIONER FIRESTONE: I am referring
14 to the Australian system as it now exists and the answer
15 is that you are not in favour?

16 DR. McMILLAN: That is right. That
17 does not mean sir that we have closed our eyes but at the
18 moment that is our case.

19 DR. RABSON: Experimentation in this
20 field may change our mind.

21 COMMISSIONER FIRESTONE: The question
22 that was under discussion is whether we are talking of
23 a Government plan or a private plan and I understood that
24 you are against the application or the use of the principles
25 embodied in the Australian scheme, which does involve the
26 use of a Government program?

27 DR. RABSON: Yes. I just want to make
28 it clear that if this plan worked out then we would welcome
29 the Government's participation for those that need the
30 help.

31 THE CHAIRMAN: You are familiar with
32 the Australian plan, as we know. Where do the funds
33 come from, from which the refund is made in Australia? I



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Quintin 12961

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DR. QUINTIN: It is two sources: the Government moiety and the plan moiety, as they call it.

THE CHAIRMAN: Where does the plan moiety come from? Is that a premium?

DR. QUINTIN: Yes, that is from a premium on a voluntary basis run by a non-profit organization. The special funds take care of indigents.

DR. McMILLAN: The Government's contribution is made on a listing of procedures and plan and recovered from the Government X dollars for X procedure out of the refunds which they have made, but the total refund is not to be more than 85%.

THE CHAIRMAN: We are talking about how the fund is built up.

DR. McMILLAN: You can insure for one moiety and the Government will match another moiety but the total of these the Government pays must never be more than 85%.

COMMISSIONER FIRESTONE: You would not feel you would want to go as far in Canada as in Australia?

DR. McMILLAN: Not at the moment.

DR. QUINTIN: We should certainly experiment. That is what is meant by this here.

DR. McMILLAN: First of all it is true there is one source of funds from the Federal Government in Australia and that is a little different from our setup here.

DR. RABSON: We believe that for this low income group that need help that first dollar coverage



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Rabson 12962

is necessary. That particular group do not want a refund system. There must not be any dollar bar to their getting medical services. There is a positive side as well as a negative side.

THE CHAIRMAN: What happens to the welfare patient in Australia?

DR. QUINTIN: He is taken care of by the special fund.

THE CHAIRMAN: Therefore, he is not included in this question?

DR. QUINTIN: No.

COMMISSIONER FIRESTONE: You mentioned certain aspects which you considered desirable and which you personally would favour adopting in Canada. What did you have in mind?

DR. QUINTIN: Well I think, first of all, the co-operation that exists between the profession, through the plan, and the Government and the mutual trust which exists, which has not been in evidence in anything which we have seen so far in any attempt of this sort of thing in our country.

The other thing is the cheapness of it. The Government is very happy to have it administered by the prepaid plans because the cost in this way is kept down remarkably low and the profession is well disciplined. The disciplining of the plan is left in the hands of the profession, with the Government's concurrence. Members are selected and are nominated by the profession and from this group a selected group is made of individuals that discipline the plan.



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of the profession are not allowed to

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That is why the plan



Quintin 12963

It is very effectively disciplined.

COMMISSIONER FIRESTONE: Would you feel, from your knowledge of the Australian plan, that the fact the Federal Government of Australia makes a financial contribution to the cost of medical care service, that this has not contributed to any deterioration of quality of medical care service?

DR. QUINTIN: The Australians are not quite sure of that themselves. In South Wales they are making a study of that at the present time. There may be, but they are not sure.

I think the quality of medical care in Australia is very good. This is a rather superficial observation but it is good. We saw where a man takes care of as high as eighty or ninety patients in a day. This is undesirable under any plan.

COMMISSIONER FIRESTONE: We accept any comments you may make in as qualified a manner as you may wish to make them. Would you feel a refund system could be a system that could provide such medical care service, the Canadian public adopt it here, and still be acceptable, perhaps in due course, to the medical profession? Have you any views on this?

DR. QUINTIN: My views are personal. As far as that is concerned, I think, yes, it has certain things which would commend itself to me as far as working out a scheme for the health care of the Canadian people.

COMMISSIONER FIRESTONE: Thank you very much.

DR. McMILLAN: There are two things in



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McMillan 12964

the Australian system, of course, which are very significant. One is that a large proportion of the care given is not covered under the plan at all. Many of these services given to patients in hospitals are not paid for from any source whatsoever and the number of beds can be controlled by the Government, as to how many patients can be put in there, and irrespective of whether or not you have insurance if they put anybody in the bed in the hospital the doctor is not paid. That cuts the cost down a great deal.

I am not sure of the number of plans that are involved but it is considerable.

DR. QUINTIN: About fifty-two different plans operating. The plan is, as Dr. McMillan stated, subsidized to that extent by the honour system of consultations in the charity hospital.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER BALTZAN: Just one thing on page 8. The Committee on Prepaid Medical Care of The Canadian Medical Association has recently recommended to T.C.M.P. member plans that if their basic comprehensive contracts do not already include them, the following benefits be made available, et cetera. I have no questions in that respect but the next page, "refractions when performed by a physician".

I do not want to put a pebble in nice peaceful water, but do you mean any physician? Do you mean a physician refractionist? We have got to know.

DR. WODEHOUSE: I cannot give you a



McMillan 12004

the Australian system, of course, which are very significant. One is that a large proportion of the care given is not covered under the plan at all. Many of these services insurance if they put anybody in the bed in the hospital the doctor is not paid. That cuts the cost down a great deal.

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Wodehouse

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5 here by a physician. There are still some physicians
6 in general practice, and so on, in rural areas who do do
7 refractions.

8 I do not believe there are very many
9 now. There are still some left which would qualify.
10 The vast majority, to which we refer here, are generally
11 qualified ophthalmologists, certified specialists. Still
12 a fringe, what they call the granddaddy clause which
13 permits an elderly practitioner, who has been doing it
14 throughout his life, to continue to do it.

15 DR. McMILLAN: There are a few who are
16 limited in their practice to ophthalmology. Those who
17 are, are not certified specialists in the sense we know
18 them today.

19 COMMISSIONER BALTZAN: You still leave
20 it in the hands of a physician fully trained as an
21 ophthalmologist, apparently trained as an infractonist
22 and a residue of people who may require that same atten-
23 tion and the personnel is not there, how would one deal
24 with it?

25 DR. WODEHOUSE: Remember this is re-
26 ferring to our own doctor-sponsored plan. These plans
27 we devised to pay physician services and there are limi-
28 tation within these plans as to physicians.

29 DR. RABSON: In Manitoba where we have
30 a welfare problem carried by our doctor-sponsored plan,
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Wodehouse

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Rabson 12966

which can be learned from examination of the eye may be missed by an optometrist. This is the way we have solved this problem.

COMMISSIONER BALTZAN: You have already extended yourself to include the actual work being done?

DR. RABSON: The plan does not pay the optometrist. The Government pays him. The plan pays the physician.

THE CHAIRMAN: It looks like a pretty expensive way of handling it.

DR. RABSON: If you want the highest standards of health care, they are expensive.

THE CHAIRMAN: Without being facetious.

DR. RABSON: I was not being facetious sir. We are concerned with the optometrist. The ophthalmologist, we feel, is qualified to discover diseases which very often manifest themselves through the eyes.

THE CHAIRMAN: We are talking here of refractions. These optometric people are qualified to make refractions.

DR. RABSON: Not by the use of drugs whereby the eye can be examined properly.

THE CHAIRMAN: We are not talking about that. We are talking about refractions and they make them by the thousand do they not? So that in Manitoba, before you refund what a patient pays the optometrist, he has got to go and have another examination by a physician, right? I make no comment at all. I will let silence shriek.

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DR. WOODHOUSE: I do not know whether



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there are any more questions. Are there any more questions sir? I have one generalization which I would like to make.

COMMISSIONER GIRARD: Did you say they had to go and see a doctor, or general practitioner before seeing an optometrist or an ophthalmologist?

DR. RABSON: Optometrist.

COMMISSIONER GIRARD: The individual would see an optometrist?

DR. RABSON: Yes.

COMMISSIONER GIRARD: Provided he is referred by a doctor?

THE CHAIRMAN: Not referred by a doctor, he has just got to be checked by a doctor.

COMMISSIONER BALTZAN: He may go and see an ophthalmologist off the street, after seeing a doctor.

THE CHAIRMAN: Do you wish to make any comment?

DR. WODEHOUSE: Mr. Chairman, when we asked for this Commission, it was our feeling that we would be seeking a complete review of all the aspects of the health service, and judging by the volume of transcript which I have received through the year, you have had a very complete expression of opinion from many, many people.

Our views, which have been put forward to you, reflect the policy of our Association as they stand today. Now our policy is subject to revision and review from time to time and has been for many, many years

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We have tried to give you our impression of what we feel is the best solution to the problem which you have to try and solve. If at the termination of these hearings there are areas in which you would like to have further discussions with our Association, I am sure that my colleagues, or whoever may be representing the Association at that time, would be only too pleased to meet with you and to discuss the matters again.

Following the submission of your report to Government, if Government wishes to have a discussion with us on any aspect of these health services, certainly we would be only too pleased, in fact anxious, to participate in such discussions.

Depending upon your report sir, it may be necessary for us to revise some of our Association policy and we have accepted this as a fact of life. We hope it will not be necessary, but it may be and if it is sir, we would like the opportunity to go back and do some self-examination and come to you, or come to Government again later. We do not wish you sir to feel that what is put in your report, or what is decided by Government is going to meet complete opposition when we have looked at it. The things you have heard so far are our official policies as of today.

THE CHAIRMAN: Thank you very much Dr. Wodehouse. That is the attitude that we would naturally expect your Association would take, and we have had a great deal of co-operation from your Association,

and what our policy is today may not necessarily be our detailed policy tomorrow, or next week or next year. We have tried to give you our impression

of what we feel is the best solution to the problem which you have to try and solve. If at the termination of these hearings there are areas in which you would like to have further discussions with our Association, I am sure that my colleagues, or whoever may be representing the Association at that time, would be only too pleased to meet with you and to discuss the matters again.

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from the Provincial Association.

That we have had to question you at length here, and in Toronto, and in the Provinces, only indicates that we feel you are a source of help and information we can tap, and certainly we know that in the course of our deliberations in the coming months if we feel that we need to open up some area or topic, we will unhesitatingly do so, and we will be expecting the same type of co-operation as we have had from the very beginning.

As this does close the public hearings, so far as you are concerned, I think all the Commissioners here would want me to say how grateful we are to the Canadian Medical Association, to the various Provincial Associations for the help we have had from organized medicine in Canada.

DR. WODEHOUSE: Thank you very much.

---WHEREUPON HEARINGS ADJOURNED

TO 9:30 A.M., WEDNESDAY, OCTOBER 17, 1962.



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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

OTTAWA

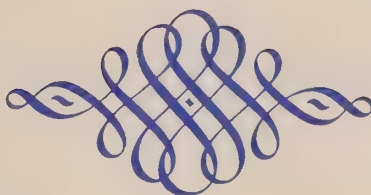
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3 ROYAL COMMISSION ON HEALTH SERVICES

4
5 Proceedings of the hearings held
6 in Ottawa, Ontario, on the 17th
7 day of October, 1962.

8 COMMISSION MEMBERS:

9
10 Chief Justice EMMETT M. HALL -- Chairman
11 Miss ALICE GIRARD, R.N.
12 Dr. C. L. STRACHAN
13 Dr. ARTHUR F. VAN WART
14 Mr. M. WALLACE McCUTCHEON, Q.C.
15 Prof. O. J. FIRESTONE
16 Dr. DAVID M. BALTZAN

17 COMMISSION COUNSEL:

18 Mr. R. N. HALL, Q.C.
19

20 MEDICAL CONSULTANT:

21 Dr. PIERRE JOBIN
22

23 DIRECTOR OF RESEARCH:

24 Prof. BERNARD BLISHEN
25

26 COMMISSION SECRETARY:

27 Mr. N. LAFRANCE
28
29
30

BY HEALTH SERVICES

Proceedings of the hearings held
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Chief Justice DONALD W. HALL -- Chairman

Mrs. ALICE GIBSON, C.M.

Dr. ARTHUR P. VAN WART

Prof. O. J. WILSON

Dr. DAVID L. BARTON

COMMISSIONER GENERAL:

MEMORIAL CONSULTANT:

DIRECTOR OF RESEARCH:

Prof. BERNARD BARTON

COMMISSIONER GENERAL:



Ottawa, Ontario,
October 17, 1962.

---UPON RESUMING AT 9:30 a. m.

THE SECRETARY: Mr. Chairman, the next submission is that of the Canadian Labour Congress to be marked as Exhibit R-7.

---EXHIBIT No. R-7: Submission by the Canadian Labour Congress.

SUPPLEMENTARY SUBMISSION BY THE CANADIAN
LABOUR CONGRESS

Appearance: Claude Jodoin
A. Andras
Joseph Morris
Russell Bell

MR. JODOIN: Mr. Chairman and Members of the Commission:

1. The Canadian Labour Congress makes this additional submission in order to deal with matters raised by other organizations which have appeared before you. We have chosen to reply to two major proposals that have been made to you: (1) that a program of health care for the Canadian people should be established through the use of voluntary agencies and (2) that, for the purpose of financial participation in the schemes operated by such voluntary agencies, a subsidy be provided by the state on behalf of those persons who are unable to pay the premium themselves in whole or in part. There are two organizations in particular which have made detailed representations to you on these matters, the Canadian Health Insurance Association.

2. It seems clear, by and large, that there is almost universal agreement that all Canadians should have all needed health care services available to them without any financial obstacle standing in their way, that such services should be of a high quality, and that there should be a sufficiency of personnel and facilities to make such services available as needed. There is thus a wide consensus on the principle of a



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---EXHIBIT N-7: Submission by the Canadian

SUBMITTAL BY THE CANADIAN

Witness:
Mr. J. L. ...
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Mr. J. L. ...

Mr. J. L. ... Mr. J. L. ... and Members of

the Commission:

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this additional submission in order to deal with matters

raised by other organizations which have appeared before

you. We have chosen to reply to two major proposals that

have been made to you: (1) that a program of health care

for the Canadian people should be established through the

use of voluntary agencies and (2) that, for the purpose

of financial participation in the scheme operated by such

voluntary agencies, a subsidy be provided by the state on

behalf of those persons who are unable to pay the premium

themselves in whole or in part. There are two organiza-

tions in particular which have made detailed representations

to you on these matters, the Canadian Union Insurance

2. It seems clear, by and large, that

there is almost universal agreement that all Canadians

should have all needed health care services available

to them without any financial obstacle standing in their

way, that such services should be of a high quality, and

that there should be a sufficiency of personnel and

facilities to make such services available as needed.

There is thus a wide consensus on the principle of a



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2 universal health care program. It is noteworthy also
3 that a number of briefs by various kinds of organizations
4 share the view of the Canadian Labour Congress that the
5 realization of the objectives just expressed can best be
6 achieved through a public health care program, that is,
7 through a program under government auspices. It is in-
8 dicative that the organizations supporting this point of
9 view represent a broad cross section of the Canadian
10 people and not merely any one group. Accordingly it
11 merits serious consideration.

12 3. In our consideration of the position
13 taken by the Canadian Medical Association, we propose to
14 confine ourselves to that section of the brief contained
15 in paragraphs 174 to 207 inclusive. The first point that
16 we wish to challenge is a statement contained in paragraph
17 176. It states:

18 4. "We subscribe to the view that
19 the needs of individual Canadians will
20 best be met if they are able to choose
21 from a variety of carriers the specific
22 contract which fits their needs and that
23 they may elect not to utilize the devices
24 of insurance if they choose. The com-
25 petition which has existed between
26 physician-sponsored plans and those of
27 the units of the insurance industry has
28 been of benefit to the public. The sub-
29 stantial improvement in the range of
30 benefits covered has resulted in part
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universal health care program. It is noteworthy also that a number of other kinds of organizations share the view of the Canadian Labour Congress that the realization of the objectives just expressed can best be achieved through a public health care program, that is, through a program under government auspices. It is indicative that the organizations supporting this point of view represent a broad cross section of the Canadian people and not merely any one group. Accordingly it merits serious consideration.

3. In our consideration of the position taken by the Canadian Medical Association, we propose to confine ourselves to that section of the brief contained in paragraphs 174 to 207 inclusive. The first point that we wish to challenge is a statement contained in paragraph 176. It states:

4. "We subscribe to the view that the needs of individual Canadians will best be met if they are able to choose from a variety of carriers the specific contract which fits their needs and that they may elect not to utilize the services of insurance if they choose. The competition which has existed between physician-associated plans and those of the units of the insurance industry has been of benefit to the public. The sub-

stantial improvement in the range of benefits covered has resulted in part from this competition and also from the increased knowledge of costs and techniques which experience has provided." (emphasis



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5. In our submission to you (paragraph 41 to 53 inclusive, and paragraphs 173 to 179 inclusive) we submitted arguments to show that the existence of "a variety of carriers" does not lead to good quality health care. On the contrary, as long as the cost of the premium is a deciding factor, some people inevitably will get only very limited benefits because of their limited resources. Competition between carriers, instead of improving the package of benefits, may result in an offer of a more limited range of benefits or, conversely, a relatively good range of benefits may be priced out of the market for some groups. In this connection it is instructive to read an item which appeared in the "Detroit Free Press" on February 4, 1962 (reprinted in "Public Health Economics", March 1962 issue; published by The School of Public Health, University of Michigan):

6. "A vigorous battle for 450 million dollars in health insurance premiums paid annually by Michigan residents is affecting the State's entire group insurance picture.

7. "The antagonists are 250 commercial insurance companies on one side, and the non-profit Michigan Blue Cross and Blue Shield organizations on the other...

8. "At issue are the divergent theories of operation used by the Blue plans and the private carriers.

9. "Blue Cross and Blue Shield use the community rating system of setting



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6. "A vigorous battle for two million dollars in health insurance premiums paid annually by Michigan residents is affecting the state's entire group insurance system."

7. "At issue are the divergent theories of operation used by the Blue Cross and the non-profit Michigan Blue Cross and Blue Shield organizations on the one hand, and the for-profit insurance companies on the other."

8. "Blue Cross and Blue Shield use the community rating system of setting



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fees. This means all subscribers are lumped together under a common payment schedule. The good risks make up the losses brought on by the bad risks.

10. "The commercial companies use the experience rating system. Each contract group has a payment schedule based on its use of insurance benefits. The healthier groups pay lower premiums and the groups with a higher incidence of illness pay higher premiums.

11. "Through their flexible premium schedules the commercial companies are slowly luring the low-risk groups away from the Blue Cross- Blue Shield fold.

12. "If the Blue plans are left with a higher proportion of poor risks it can mean even higher premiums for all subscribers.

13. "'This is more of a social problem than a Blue Cross problem', says William S. McNary, executive vice-president of Blue Cross. 'Experience rating carried to its logical conclusion means the good and average risks will be insured while the high risks who really need insurance are priced out of the field. If the commercial carriers are allowed to continue without taking a proper share of older people there is no question that it

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will affect our community rating system. We would probably have to turn to some modified rating system to keep operating."

14. "Spokesmen for the private companies say the Blue plans are having trouble because they offer too many benefits and are too rigid. 'Very few of our contracts offer the services offered by Blue Shield and Blue Cross,' said one. 'The Blue plans aren't flexible. We find out what a contract group wants to spend and then tailor a contract providing all benefits possible for that price. If a rate increase is indicated we can give an option of reducing the benefits. Blue Cross has a practice of asking for rate increases and then throwing in more benefits to ease the sting. The additional benefits only bring on a need for more rate increases.' ..."

(emphasis ours).

15. It may be seen from the foregoing that the competition of the market place in the field of private health care plans does not necessarily result in any improvement for subscribers or would-be subscribers.

16. There is a discrepancy in the Association's brief. In paragraph 180 it is estimated that by 1965 approximately 63.2 per cent of the population will be covered by prepayment plans for medical services and that by 1970 coverage will have reached 67 per cent. In paragraph

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188, however the figures are 67 per cent and 71 per cent respectively. (The figures for current coverage are also inconsistent: 56 and 60 per cent respectively.) Our purpose is not merely to draw your attention to a discrepancy. What we wish to stress here is the implication of the figures, regardless of which set is used. Assuming that the estimate of 71 per cent for 1970 is the more accurate, it serves to underline the fact that the possibility of universal coverage through voluntary action within the near future is extremely remote. Judging from the figures contained in paragraph 188, the increase between 1965 and 1970 would be less than one per cent per year. Accordingly, assuming the same rate of increase after 1970, it would take well into the next century before total coverage could be achieved through the private carriers. We submit that this kind of leisurely progress -- if progress it is -- is inconsistent with present needs. It is inconsistent also with the statement in the same brief (paragraph 190) that "insurance to prepay the costs of medical or financial status." If this is an objective of the Canadian Medical Association, it should be one attainable within the lifetime of most of those who are now alive.

17. The principal issue, however, on which we consider the Canadian Medical Association to be open to criticism is its proposal that the means test principle be employed to provide coverage for a considerable number of Canadians who would otherwise not be able to pay the premium for such coverage either in whole or in part. According to the Association's estimates



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(paragraphs 199 and 203) approximately 4,500,000 persons would fall into this category.

18. We question whether the Canadian Medical Association has fully appraised the implications of its proposal. The suggestion that a means test be applied to almost one-fourth of the Canadian population, and to a very much larger proportion if only the adult population is considered, bears within it consequences that are not brought out in the Association's brief.

19. In our own submission, we made brief reference to the stigma or loss of self-respect with which a means test is associated in the minds of many of our people. We concede, however, that notwithstanding this feeling, there is a legitimate place in a system of social insurance for benefits which are made available only on a means test basis. But we question whether a means test should be more than marginal in its application. At the same time, we do not want to understate our objections to the effect of a means test on the individual. The extensive information which an applicant for assistance must furnish, much of it which is quite private in character, is bound to make the use of this procedure repugnant to many people. (See, for example, Form 2 under the General Welfare Assistance Act of Ontario: "The General Welfare Assistance Act, 1958, and Regulations", published by Ontario Department of Public Welfare, 1960.)

20. It is well to remember that the scope of the questions involved in an application for social assistance is based, first, on the fact that such



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assistance is intended to be related to need and, second, that it is presumed to apply to a relatively small part of the population. It should not be applicable where the need for assistance is likely to be permanent or indefinite. Thus, Professor John Morgan has seriously questioned the wisdom of maintaining a test in the case of providing allowances for disabled persons where the evidence showed that the vast majority were entitled to the maximum benefit. ("The Changing Welfare Pattern", by John S. Morgan; paper delivered to the Mid-Winter Conference, Community Funds and Councils Division, Canadian Welfare Council, February 14, 1962). It is a moot point whether it is either desirable or possible to legislate a requirement which, on the Canadian Medical Association's own estimate, would require over 4,500,000 Canadians to satisfy a test to which in their minds would be attached the stigma of indigency. We must bear in mind further that for a considerable number of them the test would still have to be applied even though the degree of assistance might be quite limited. Are we prepared to engage in a wholesale scrutiny of the private affairs of millions of Canadian citizens?

21. We would argue further that the Canadian Medical Association has failed, in its assessment of possible costs of coverage for indigents, to take into account the administrative aspects of subjecting more than 4,500,000 Canadians to a test before they can become eligible for medical services. Where need must be proved, as in the case of social assistance, it is not sufficient to prove it once and for all as is the case, for example,



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5 peatedly in order to maintain entitlement. This was
6 very clearly set out in a pamphlet published by the
7 Department of Social Welfare and Rehabilitation of the
8 Province of Saskatchewan, in 1958. Entitled "Public
9 Assistance in Saskatchewan", the pamphlet stated: "The
10 official to whom the municipality has assigned responsi-
11 bility for the administration of social aid should review
12 the recipient's circumstances periodically and adjust
13 his allowance accordingly. The frequency of these re-
14 views should be determined by the likelihood of change
in the recipient's circumstances."

15 22. In connection with the Association's
16 proposal, it may be well to ask whether public subsidy
17 to any individual applicant would be based on an annual
18 check of his circumstances, a quarterly check, a monthly
19 one or any other. The more frequently the check, the
20 costlier the procedure would be. Conversely, the less
21 frequently it took place, the more likely that a subsidy
22 was being advanced to some who were no longer entitled
23 to it. A follow-up on a monthly basis might result,
24 on the basis of the Association's estimates, in more than
25 54 million procedures a year; a quarterly check would
26 still require as many as 18 million. There might pre-
27 sumably be some who could be declared permanently indigent
28 for the purposes of a health care program, for example,
29 those living exclusively on old age security or old age
30 assistance. But there would obviously be a good many
others whose categorization as indigents would be
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that they would have to be checked with some degree of frequency. Accordingly, regardless of how or on what basis follow-ups were to take place, it seems clear that the problem is a formidable one involving a large staff of qualified social workers and other personnel and creating a considerable expenditure of public funds.

23. It is to be noted that the Association has referred only to medical services and to the provision of drugs. The Association has, in effect, assumed a relatively limited program of public health care, one confined by and large to the services rendered by the physician and to the medicines which a physician might prescribe. The Association has therefore excluded from its considerations the provision of applicances, dental services, private duty nursing services, and other services in the field of health care. All of these are being made use of to a greater or lesser degree and are being paid for, except in the case of indigents, for the most part through direct payment by the patient to the provider of the service. As has been indicated to you in our own brief and in others, there are a good many Canadians who are not getting as much of the services as they should, more particularly in the field of dental care but otherwise as well. If the range of health care services were to be made truly comprehensive, as we have suggested, and if the Association's proposals were to be extended accordingly, it seems reasonable to assume that the number of those who would be forced to seek public support would be very much augmented. The Association's estimate of over 4,500,000 would in all



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likelihood reach a figure of such magnitude that the imposition of a means test would be virtually impossible. There is in addition the very obvious fact that private prepayment plans, whether of the non-profit or commercial variety, have so far signally failed to provide dental services, and have restricted the provision of drugs, nursing, and appliances (while excluding eye glasses or hearing aids) to coverage under the so called major medical benefit plans with their costly deductible and co-insurance charges. It is too much to expect that a complete range of services can be made available on a universal basis to the Canadian people within the near future through the mere extension of the private prepayment schemes. It is not physically, financially nor administratively possible.

24. The arguments advanced by the Canadian Medical Association in favour of prepayment plans under private auspices have been based on more than the conviction that these plans were sufficient to take care of the medical needs of the Canadian People. It seems quite clear that support for these plans reflects a determination on the part of the organized medical profession not only to control the practice of medicine itself in a professional sense but also the methods whereby the provision of medical services may be financed. This has been very clearly brought out in a statement by the President of the Canadian Medical Association: (Saskatchewan - Before, During and After" by W. W. Wigle, M.D., C.M., President Elect, The Canadian Medical Association, in the Canadian Medical Association Journal",

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September 8, 1962 issue):

25. "The medical profession must be impressed with the fact that a large segment of the population want to prepay their medical care completely. It is also obvious that many people would have no objection to the funds being raised by taxation.

26. "We in the profession must face these issues and act in accordance with our beliefs. The prepayment of medical care in all its phases -- the collection of the funds, the administration and the payment for the services -- must be more diligently studied and controlled by the profession or it will be done by someone else. No one else should be acceptable to use because those who control these factors on a completely comprehensive basis, which is what the people desire, will control medicine. The methods of control must be acceptable to the profession, impressive to the Government and the populace, and efficient in order to overcome serious business opposition." (emphasis ours)

27. There can be no argument about the fact that the medical profession alone is in a position to judge the competence of a physician and of the quality of the services that he renders. This can be



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5 taken as a self-evident proposition. But it is not as
6 self-evident as the President of the Association would
7 make out, that the medical profession should enjoy what
8 is obviously intended to be a monopoly control by it
9 over such aspects of medical care as its financing and
10 administration. We cannot see what justification there
11 could be for handing over in its entirety to the medical
12 profession the full disposition of all medical care,
13 including "the collection of the funds, the administration
14 and the payment for the services" to a group that very
15 obviously has a direct stake in these things from a very
16 sectional point of view. A conflict of interest would
17 seem to be unavoidable. Moreover, we question the
18 desirability of allowing any group to enter into and to
19 take control of an essential service and make it its
20 private property, allowing the group to exercise sovereign
21 powers over matters which are essentially fiscal and
22 should more properly be in the public domain. To allow
23 the medical profession to do what Dr. Wigle proposes
24 would be nothing less than medical syndicalism: control
25 by the medical profession over features of medical care
26 which should not be their concern alone. Under such an
27 arrangement it is almost inevitable that the public
28 interest would be secondary. If neither Parliament nor
29 the Legislatures are to intervene, and if the consumer
30 interest is not to be represented otherwise as well, there
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28. The brief submitted to you by the Canadian Health Insurance Association raises a number of other issues with which we propose to deal with here. This Association shares with the Canadian Medical Association the belief that the government should intervene only on behalf of those who cannot cover their own costs of health care. We have already dealt with this above and will refrain from any further comments here.

29. The brief in general reflects certain value judgments which we cannot share. It represents essentially the viewpoint of a group which exists purely as a commercial venture. This does not expose it to condemnation but it does indicate that the Association's viewpoint on a matter of public concern such as the health of the Canadian people must inevitably be coloured by some degree of self-interest. Above and beyond that, the Association is so conditioned to think in terms of its own type of operation, that is, one of competition in the open market by a relatively large number of carriers, that it finds it difficult to express itself in ways other than that of a seller. The satisfaction of consumer need, in this instance the requirement of adequate health care services, is regarded merely as a means to an end, the end being a profitable transaction.

30. On the basis of its own preconceived notions, furthermore, the Association makes statement without any supporting evidence. Thus, for example, it states with reference to a public plan that "The

18. The brief submitted to you by the Canadian Health Insurance Association raises a number of other issues with which we propose to deal with here. This Association shares with the Canadian Medical Association the belief that the government should intervene only on behalf of those who cannot cover their own costs of health care. We have already dealt with this above and will refrain from any further comments.

19. The brief in general reflects certain value judgments which we cannot share. It represents essentially the viewpoint of a group which exists purely as a commercial venture. This does not expose it to condemnation but it does indicate that the Association's viewpoint on a matter of public concern such as the health of the Canadian people has inevitably been coloured by some degree of self-interest. Above and beyond that, the Association is so conditioned to think in terms of its own type of operation, that is, one of competition in the open market by a relatively large number of carriers, that it finds it difficult to express itself in ways other than that of a seller. The satisfaction of consumer need, in this instance the requirement of adequate health care services, is regarded merely as a means to an end, the end being a profitable

20. On the basis of its own preconceived notions, furthermore, the Association makes statement without any supporting evidence. Thus, for example, it states with reference to a public plan that "The



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possibility of qualitative and q-antitative deterioration of health care services should not be overlooked"

(page 10, paragraph 3. (8)). So strongly suggestive a statement should be backed up by supporting evidence.

In view of the considerable number of public plans that exist in other parts of the world, any evidence in support of such a statement should surely have to come to the attention of the Association.

31. The proposition is made in paragraph 3 (1) of the brief (Section B) which expresses as an advantage the fact that medical care insurance would cover "the bulk of the important cost that most frequently occurs" and that such insurance would be made available "to everyone who can pay the premiums". We have advanced reasons to support our contention that all costs should be covered and not merely "the bulk of the important cost" since otherwise the person or family requiring health care services may not get all the services required. The relationship of services to ability to pay is highly objectionable and we have attempted to demonstrate this in our brief as well.

32. An important part of the Association's submission is an effort to prove through actual case histories that the insurance industry is able to pay a substantial portion of the costs of accident or illness suffered by insured persons. It is highly significant to us that the Association's claim is not at any time that its members are either able or willing to cover all the costs of accident or illness but at best "a substantial portion" (see paragraph 9). The case histories



possibility of qualitative and quantitative deterioration of health care services should not be overlooked" (page 10, paragraph 3, (b)). So strongly suggestive a statement should be backed up by supporting evidence, in view of the considerable number of public plans that exist in other parts of the world, any evidence in support of such a statement should surely have to come to the attention of the Association.

31. The proposition is made in paragraph 2 (1) of the brief (Section B) which expresses as an advantage the fact that medical care insurance would cover "the bulk of the important cost that most frequently occurs" and that such insurance would be made available "to everyone who can pay the premiums". We have advanced reasons to support our contention that all costs should be covered and not merely "the bulk of the important cost" since otherwise the person or family requiring health care services may not get all the services required. The relationship of services to ability to pay is highly objectionable and we have attempted to demonstrate this in our brief as well.

32. An important part of the Association's submission is an effort to prove through actual case histories that the insurance industry is able to pay a substantial portion of the costs of accident or illness suffered by insured persons. It is highly significant to us that the Association's claim is not at any time that its members are either able or willing to cover all the costs of accident or illness but at best "a substantial portion" (see paragraph 9). The case histories



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which comprise Appendix IV to the brief are quite instructive in this respect. They show in some instances that the claim has been paid either entirely or to the extent of better than 90 per cent of the bill. This presumably is a strong argument from the Association's point of view. A careful examination of the various claims, however, indicates that in a very considerable number of cases and more particularly those in which large costs were incurred, the insurance companies concerned left their subscribers with heavy burdens of medical indebtedness. Thus in Claim No. 4 of Company "A", the patient was left to cover \$198.00 out of a \$599.00 bill, or almost one third of the total. In claim No. 6, the insured was left to pay \$2,664.00 out of a total of \$8,950.00 or nearly 30 per cent of the total. In the case of Company "C", Claim Example No. 1 illustrates illness of long duration. In this instance the insured was left to pay \$2,483.00 out of a total of \$10,621.00 or somewhat more than 23 per cent of the total. In the case of Claim Example No. 2, submitted by the same company, the insured paid \$1,517.00 out of a total cost of \$5,832.00, or 26 per cent of the total. Rather than elaborate further in this regard, we have tabulated all the case histories in order to indicate to what extent the insured was required to cover part of the cost of the bill:



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Company Examples	Dollar Amount Payable by Insured		Percentage Amount Payable by Insured	
"A"	1.	\$ 29.00		8.5%
	2.	81.70		39.2
	3.	15.00		7.3
	4.	198.00		33.2
	5.	108.20		16.6
	6.	2,664.00		29.8
"B"	1.	154.75		17.0
	2.	360.60		17.0
	3.	69.20		9.0
	4.	108.50		25.0
"C"	1.	2,482.78		23.4
	2.	1,517.36		26.0
	3.	929.87		23.1
"D"	1.	533.78		20.8
	2.	1,014.81		22.7
	3.	651.80		21.4
"E"	1.	8.50		6.8
	2.	41.00		8.6
	3.	363.61		21.2
	4.	120.43		25.6
	5.	552.00		23.4
"F"	1.	--		0.0
	2.	10.00		3.8
	3.	193.00		28.9
	4.	25.00		17.2
	5.	5.00		18.5
	6.	15.00		6.8
	7.	--		0.0



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(continued)

Company Examples	Dollar Amount Payable by Insured	Percentage Amount Payable by Insured
8.	--	0.0
9.	--	0.0
10.	15.00	5.1
11.	20.00	8.2
12.	5.00	4.0
13.	196.45	21.9
14.	5.00	2.8
"G" 1.	469.40	10.8
2.	394.30	21.8
3.	504.89	21.7
4.	139.80	13.7
5.	12.50	4.1
6.	279.94	28.0
7.	31.74	14.6
"H" 1.	217.52	24.9
2.	2,413.43	38.7
3.	156.30	22.3

33. It may be seen from the foregoing that out of the 45 examples provided, in only 4 cases did the carrier cover the total cost incurred. In 21 cases, the insured was left to cover more than 20 per cent of the total cost and in another 8 between 10 and 20 per cent. In terms of absolute dollars payable, 10 of the insured were left to pay amounts in excess of \$500.00; 23 had to cover \$100 or more (including the 8 already mentioned). Since these are examples submitted by the insurance industry itself, we assume that they consider this to be



(continued)

Payable by Insured
Payable by Insured

0.0

0.0

13.01

10.00

2.01

2.00

100.00

100.00

11.01

11.75

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to cover \$100 or more (including the 8 already mentioned). Since these are examples submitted by the insurance industry itself, we assume that they consider this to be



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eminently creditable performance. We beg to differ. We consider this table an illustration of how deficient commercial insurance can be in meeting the health care costs of the Canadian people. A contract which leaves the insured to pay \$2,664.00 or nearly 30 per cent of the total (company "A", Claim No. 6) can hardly be said to have looked after the health costs of this particular person. It should not be necessary, however, to take so extreme a case. Even smaller amounts are considerable both in absolute terms and as a ratio of the total cost, for example, \$360.60 and 17 per cent respectively (Company "B", Claim No. 2); \$552.00 and 23.4 per cent respectively (Company "E", Claim No. 5); \$196.45 and 21.9 per cent (Company "F", Claim No. 13).

34. Consideration must surely be given to ability to pay and not merely to degree of coverage. The question is therefore whether the majority of Canadian families are in a position to pay substantial medical costs without at the same time having to cut down on other necessary family expenditures. Some indication of ability to pay may be obtained from examining income tax statistics. In the year 1959, out of a total of 4,242,490 Canadian tax payers, 3,317,762 were in income classes of less than \$5,000.00 a year. (Taxation Statistics 1961, Department of National Revenue). These are figures of individual tax payers but it is worth noting that a survey made by the Dominion Bureau of Statistics showed that in a sample of 1,088 families 721 or 66.3 per cent had incomes from all sources of less than \$5,000.00 a year (D.B.S. "City Family



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Expenditure 1957"). We are bound to ask, therefore, whether insurance coverage which leaves relatively large amounts to be paid by the insured person over and above the insurance premium itself is an effective instrument to protect most Canadian families against the unpredictable costs of medical care. Bearing in mind, as we must, that prepayment plans do not ordinarily cover dental care and other services not provided by the physician, it is obvious that the family has a much greater health care burden than the insurance industry itself has indicated or than which it is prepared to underwrite.

35. Under Section D of the brief, the Association states (paragraph 18) that it is the function of voluntary insurance to protect the insured person "against practically all financial loss resulting from sickness or accident." The data which the Association has itself furnished and which we have dealt with above would indicate that this function is not effectively being carried out.

36. Under the same heading (paragraph 21) the statement is made (and restated in similar terms in paragraph 33) that the insured person is able under voluntary insurance to purchase a policy providing reimbursement or indemnity "according to the contract he feels best meets his needs". This reference to "needs" is at best a euphemism. Under the circumstances that now prevail, it is more likely that he will purchase which fits his means rather than his needs. It is quite clear that the insurance industry will sell a package

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21. Under Section 11 of the Act, the Association states (paragraph 11) that it is the function of voluntary insurance to protect the insured person "against practically all financial loss resulting from sickness or accident." The data which the Association has itself furnished and which we have dealt with above would indicate that this function is not effectively being carried out.

22. Under the same heading (paragraph 11) the statement is made (and repeated in similar terms in paragraph 25) that the insured person is able under voluntary insurance to purchase a policy providing reimbursement of indemnity "according to the contract in his best interests." This reference to "needs" is at best a euphemism. Under the circumstances then now prevailing, it is more likely that he will purchase which fits his means rather than his needs. It is quite clear that the insurance industry will sell a package



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of benefits that may be very restricted in scope or one relatively broad in scope. Other things being equal, it is the ability to pay that will determine the range of benefits rather than the needs of the would-be purchaser.

37. In Section F the brief states (paragraph 61) that "It is not possible to designate the percentage of Gross National Product beyond which government expenditures should not go. Obviously, however, if governments continue to take an increasing percentage of the Gross National Product, there will come a time when the incentive to strive for higher monetary rewards will be impaired at many levels of society." This statement is remarkable on a number of grounds. It is hardly necessary to provide statistical evidence to support the statement that the government today takes a much larger percentage of the Gross National Product than it did, say, in 1972. Presumably, on the basis of the Association's statement, this should have resulted in a downward trend in Canadian economic development during the last 90 years. That the opposite has occurred is so patently evident that no further rebuttal would appear to be necessary. But the Association's statement is inaccurate even in terms of what has occurred in recent years. In his budget speech of April 10, 1962, the Minister of Finance, said: "Total expenditures on goods and services by the federal government has been a smaller proportion of gross national expenditure in 1961 than they were in 1956." This was true of every single year since 1956.

of benefits that may be very restricted in scope, or one relatively broad in scope. Other things being equal, it is the ability to pay that will determine the range of benefits rather than the needs of the would-be purchaser.

25. In Section 5 the writer states

(paragraph 6) that "it is not possible to designate the percentage of Gross National Product beyond which government expenditures should not go. Obviously, however, if governments continue to take an increasing percentage of the Gross National Product, there will come a time when the incentive to strive for higher money rewards will be impaired at many levels of society." This statement is verifiable on a number of grounds. It is hardly necessary to provide statistical evidence to support the statement that the government today takes a much larger percentage of the Gross National Product than it did, say, in 1955. Presumably, on the basis of the Association's statement, this should have resulted in a downward trend in Canadian economic development during the last 20 years. That the opposite has occurred is so patently evident that no further research would appear to be necessary. But the Association's statement is inaccurate even in terms of what has occurred in recent years. In his budget speech of April 10, 1963, the Minister of Finance, said: "Total expenditures on goods and services by the federal government has been a smaller proportion of gross national expenditure in 1961 than they were in 1956." This was true of every single



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38. Appendix II of the brief is a description of an illustrative plan proposed by the Association as the means of providing extensive if not universal coverage for Canadians. The plan is described under a number of heads and we propose to deal with them in the order shown.

39. In the matter of eligibility, the Association's plan would require those wanting to join to do so within a specified period after the plan's introduction and a period of three months has been suggested. Subsequently, each year thereafter, there would be available a shorter period during which new applications could be made. We wonder why it should be necessary to have a closed season so far as applications are concerned. If membership is desirable and in the public interest, there is no reason, short of administrative convenience to the carriers concerned, why applications should not be possible at any time during the year. Such a restriction would in some circumstances result in a relatively long period during which some people would be without insurance coverage.

40. The benefits to be provided are quite clearly limited to "insurance for the expenses of surgical and medical services". Accordingly, all other health care services are to be left entirely to the resources of the insured person. This points up very sharply a basic inadequacy in this proposed plan. But assuming that this limitation could be brushed aside, the plan is still open to criticism on a number of grounds even where surgical and medical services are



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concerned. Thus it is to be noted that the plan includes "payment for physician's charges only in the event of illness or accident and the benefits are subject to an overall lifetime maximum limit per individual of \$5,000.00." It is clear therefore that preventive and rehabilitative procedures such as might be furnished by a physician are to be excluded. The insured person is thus obviously involved in an additional cost for which he can assume no indemnification or reimbursement by the insurance carrier. The lifetime maximum (whether it is \$5,000.00 or some other sum) is a further limitation and one aimed at those who are most likely to make full use of the plan, those who suffer prolonged or frequent bouts of illness. It is interesting to note that Claim No. 1 furnished by company "C" in Appendix IV would have felt the effects of this maximum very severely. This claimant, between 1958 and 1961, incurred total medical costs of \$10,621.00 over and above payments on her behalf by the Ontario Hospitals Services Commission. Under the plan covering her, the insurance company paid \$8,138.00. Under the Association's proposed plan it would have paid \$5,000.00 and would thereafter have assumed no further obligation. In other words, the insurance carrier would have ceased paying benefits well before this claimant ceased needing medical care.

41. In the case of medical care in hospital, there is a built-in limit on the amount to be paid to a certified specialist; otherwise the plan undertakes to pay the full charge according to the applicable tariff. But where the physician renders his services

concerned. Thus it is to be noted that the plan includes "payment for physician's charges only in the event of illness or accident and the benefits are subject to an overall lifetime maximum limit per individual of \$2,000.00." It is clear therefore that provisions of rehabilitative procedures such as might be furnished by a physician are to be included. The insured person is thus obviously involved in an addition of cost for which he can assume no indemnity action or reimbursement by the insurance carrier. The lifetime maximum (whether it is \$2,000.00 or some other sum) is a further limitation and one applied to those who are most likely to make full use of the plan, those who suffer prolonged or recurrent bouts of illness. It is interesting to note that Claim No. 1 furnished by company "C" in Appendix IV would have been the extent of this maximum very severely. This claimant, between 1958 and 1961, incurred total medical costs of \$10,611.09 over and above payments on her behalf by the Ontario Hospital Services Commission. Under the plan Under the Association's proposed plan it would have paid \$2,000.00 and would thereafter have assumed no further obligation. In other words, the insurance carrier would have ceased paying benefits well before this claimant ceased needing medical care.

41. In the case of medical care in hospital, there is a built-in limit on the amount to be paid to a certified specialist; otherwise the plan undertakes to pay the full charge according to the applicable tariff. But where the physician renders his services



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outside of a hospital, or in the case of out-patient service at a hospital, the benefits will be 80 per cent of the tariff (50 per cent for psychiatric care) in excess of a \$10.00 deductible per illness or accident. Accordingly, if we understand this proposal correctly, the insured person would be burdened with the charge over and above the 80 per cent (or the 50 per cent for psychiatric care) if the attending physician so insists. It is to be noted that a further complication in the relationship between the insurance carrier and the insured person has been injected by the provision that "where the illness is due to the same or related causes, a 90 day interval between services will be the criterion for determining whether the claim shall be treated as a new illness."

42. In justification of its program, the Association claims that it has "kept clearly in mind the economies which can result from the exclusion of readily budgetable items, while at the same time recognizing the importance of keeping those figures and percentages within manageable proportions for families of modest income" (Appendix II - 4). We are inclined to ask economies for whom? It is quite clear that the plan has been designed to minimize the risk to the insurance carrier while exposing the insured person to a considerable risk that he will have a burden of expenses over and above his premium if an illness or accident occurs to him or his dependents. We submit further that a co-insurance charge of 20 per cent is onerous as the examples cited by the insurance companies themselves make quite clear.



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 above his premium if an illness or accident occurs to him
 or his dependents). We submit further that a co-insurance
 charge of 20 per cent is onerous as the examples cited
 by the insurance companies themselves make quite clear.



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43. The anticipated premium for the plan is set at \$5.50 a month per adult and \$3.30 per child, with an unstated maximum per family. Since these figures will not cover all health care costs, they represent a very considerable charge to a family of modest means. The real cost to the subscriber would be very much higher than the premium rate itself. As has already been indicated, the plan is silent about the costs of dental care, nursing care, the services of the therapist, drugs, the provision of appliances, and so on. It is silent also on the question of the quality of care that will be provided or whether in fact services will be available to those who pay the premium and who find themselves in need of these services. Presumably the Association assumes that the government will see to the supply of personnel and facilities. What the plan amounts to is a request by the insurance industry for an opportunity to engage in an undertaking which must from its point of view offer an opportunity of a profitable return while asking the community at large to provide the heavy subsidies reflected in medical education, the construction of hospitals, research and so on, without which no health care program would be viable.

44. Paragraph 5 in Appendix II on the method of sharing excess medical care costs is of some interest as well. The Association contemplates a central reinsurance agency to even out the costs resulting from excess medical care costs of those people insured at the maximum premium. But this agency is not to be confined to the commercial carriers alone. The Association suggests



13. The suggested program for the

plan is set at \$5.00 a month for adults and \$3.00 for children with an unmet maximum per family. Since these charges will not cover the health care costs, they represent a very considerable charge to a family of modest means. The real cost to the subscriber will be very much higher than the premium rate itself, as has already been indicated, and plan is aimed at the costs of dental care, nursing care, the services of the therapist, etc., the provision of appliances, and so on. It is all on also on the question of the quality of care that will be provided or whether in fact services will be available to those who pay the premium and do not themselves need those services. Presumably the Association assumes that the Government will see to the supply of personnel and facilities. Since a plan known to be a request by the insurance industry for an opportunity to engage in an undertaking which must have its roots in view either an opportunity of a profitable return while asking the community at large to pay for the heavy subsidies reflected in medical education, the construction of hospitals, research and so on, without which no health care program would be viable.

14. Paragraph 5 of Appendix II on the

method of sharing excess medical care costs is of some interest as well. The Association contemplates a central reimbursement agency to even out the costs resulting from excess medical care costs of those people insured at the maximum premium. But this agency is not to be controlled by the insurance industry. The Association suggests



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that there be required to enter into the agency a variety of plans outside the insurance industry. We cannot describe this as anything else but an effort on the part of the insurance industry to hedge against anticipated high costs at the expense of other programs. This is being asked, the Association claims, so that these outside agencies should bear their "fair share" of the costs of extending the benefits of voluntary insurance to the substandard and uninsurable lives. The reference to "fair share" has a curious ring when it comes from an industry which relates its premiums to the nature of the hazard, the size of the group, its sex composition, its experience from year to year (experience rating) and so on. Quite obviously, the Canadian Health Insurance Association has been able to make its present proposal, however inadequate, on the assumption that others would be required to share a burden which it would not undertake by itself. In light of the Association's protestations about the value of voluntarism, the mandatory participation by other groups in the proposed central reinsurance agency sounds odd indeed.

45. We have refrained as much as possible from reiterating views which we expressed in our initial submission. We have attempted here to indicate in what ways two major Canadian institutions appearing before you have failed to make a persuasive statement on how the health care needs of the Canadian people should be looked after. We commend to you once again for your consideration and, we hope concurrence, the views we have expressed in favour of a public health care program.



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consideration and, we hope concurrently, the views we have



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Respectfully submitted,
The Canadian Labour Congress,
Claude Jodoin, President,
Donald MacDonald, Secretary-
Treasurer,
William Dodge, Executive Vice-
President,
Joseph Morris, Executive Vice-
President.

Ottawa, September 24, 1962.

MR. JODOIN: Mr. Chairman and members
of the Commission, I would like to introduce the
executive vice-president, Joseph Morris of our Congress,
on my right; Mr. Andrew Andras, director of our
legislative department, and Mr. Russell Bell, assistant
director of our research department.

Now, I wish to express to you immediately
and your colleagues our appreciation to have the
opportunity of making a presentation of a supplementary
submission to the original one we made a while ago.

I wonder now if it is necessary on
my part or on the part of my colleague to read the
supplementary submission, because I understand it was
submitted in advance to a certain extent, and on
procedure, Mr. Chairman, I would leave that to you,
whether you wish us to read it or if you prefer to come



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The Canadian Labour Congress,
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Donald Macdonald, Secretary-
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Mr. JOBIN: Mr. Chairman and members
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whether you wish us to read it or if you prefer to come



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to the question period, if I may use this term, or if my colleagues have any additional comments to make on the submission itself.

THE CHAIRMAN: Well, Mr. Jodoin, this has been in our hands for some time, everybody has had an opportunity to read it, and I am sure everyone has done so. So that the mere reading is not of consequence in that regard. But if you would care to supplement or develop any part of it, we would be very glad to hear from you.

MR. ANDRAS: I think, Mr. Chairman, what we may do is simply review very briefly the main points from our point of view. Actually if the brief were to be condensed it would consist of six principal points.

I should say by way of introduction that our brief is concerned with two submissions, the Canadian Medical Association and the Canadian Health Insurance Association. We consider them to be two main spokesmen, and we dealt with them and their position. We seem to have a distinctive capacity to disagree with them, Mr. Chairman.

THE CHAIRMAN: Well, you have an approach to the problems, and that is why we are anxious that you should be here and have both views fully developed.

MR. ANDRAS: Well, we disagree with both these organizations as to the efficacy of private prepayment plans, whether of the non-profit variety or those put in the marketplace by the commercial carriers.



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Johnson

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THE CHAIRMAN: Well, Mr. Johnson, this

has been in our hands for some time, everybody has had an opportunity to read it, and I am sure everyone has done so. So that the mere reading is not of consequence in that regard. But if you would care to supplement or develop any part of it, we would be very glad to hear from you.

What we may do is simply review very briefly the main points from our point of view. Actually if the brief were to be condensed it would consist of six principal points.

I should say by way of introduction that our brief is concerned with the submission, the Canadian Medical Association and the Canadian Health Insurance Association. We consider them to be two main spokesmen, and we dealt with them and their position. We seem to have a distinctive capacity to disagree with them, Mr. Chairman.

THE CHAIRMAN: Well, you have an approach to the problems, and that is why we are anxious that you should be here and have both views fully developed.

MR. ANKAS: Well, we disagree with both these organizations as to the efficacy of private prepayment plans, whether of the non-profit variety or those put in the marketplace by the commercial carriers.



Andras 12998

We have come to the conclusion by our own studies that these plans are not designed to provide the coverage and care that we believe belong to the people of this country. Even if we were to agree with these bodies, we would submit that the rate of growth is such and that the rate itself has tapered off that it would be a good many years before the people of this country could hope to be completely covered under these plans.

We have indicated to you on the basis of the data submitted by the Canadian Medical Association that the rate of expansion of these plans, based on their extrapolation of present coverage, would not completely cover every one until the turn of the next century. We think this is a far too slow rate of progress. We would like to see the people covered who are alive or will be alive.

Let us say we accept their figure. We took the data of the figures from their point of view, took their own calculation of the rate of growth, projected it and discovered that the rate was so slow that it would take another generation or more before we would hope to see all the people of this country covered. This is without prejudice to our view of the plans themselves. We deal with each separately.

The next item we deal with in our brief is the proposal of the Canadian Medical Association, supported by the Canadian Health Insurance Association, that coverage should continue to be voluntary or through voluntary agencies, but that the government should intervene on behalf of those who are unable to pay



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the premium, assuming a premium form of payment, either in whole or in part. We have once again taken the figures of the Canadian Medical Association and drawn your attention to the fact that approximately 4,520,000 people in this country would have to submit to a form of means test or needs test. We use the term as a generic term. But the fact of the matter is that on the basis of the Canadian Medical Association's calculations, approximately one-quarter of the Canadian population would have to submit to such a test, and we submit in our brief that such a system is a marginal device and not one that we should have on a wholesale basis, because of the stigma that is attached to it. Also it would mean an enormous administrative load. We probably do not have at the moment in Canada enough people that would be involved if the proposal of the Canadian Medical Association were to be implemented.

THE CHAIRMAN: You will not mind a question as you go along.

MR. ANDRAS: Certainly.

THE CHAIRMAN: What do you say as to the idea advanced yesterday, taking the income tax returns as the mechanics of the test?

MR. ANDRAS: Well, it is a blunt instrument, I might say.

THE CHAIRMAN: Well, blunt or not. I am only mentioning it because you say that because of the magnitude of the task it would take hundreds and hundreds, et cetera.

MR. ANDRAS: We were told it would take



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Andras 13000

double the numbers in Canada.

THE CHAIRMAN: Even if you used the income tax method suggested by the insurance people yesterday?

MR. ANDRAS: We merely object to this on principle.

THE CHAIRMAN: I wonder if you would have to have all this additional personnel if the income tax method was one which would determine eligibility for subsidy.

MR. ANDRAS: Well, it would depend on the procedure, because it would be a form that would be filed by the income tax payer. A considerable number of people in this country do not file returns. While by law they may be compelled to do so, they don't, and the income tax people don't bother them. Secondly, the income tax itself is not necessarily the best means of measuring ability; it is not a perfect instrument. But, in any event, it has been our position that this kind of device, the mechanics are not consequential to us so much. What we would like to see is universal coverage, with the financing done out of the exchequer. The proposal does not harmonize with our point of view.

Coming to our next point, we move to our next point and we take the statement from the Medical Association, a statement of the President Elect of that association published in its official journal on September 8th, 1962, a statement by Dr. W. W. Wigle.

THE CHAIRMAN: That is on page?

THE SECRETARY: Page 7



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Medical Association, a statement of the President Elect

of that association published in its official journal on

September 24th, 1952, a statement by Dr. W. W. Sigler.

THE CHAIRMAN: That is on page?

THE SECRETARY: Page 7.



Andras 13001

MR. ANDRAS: Yes. We took up the position taken by this obviously chief spokesman of the Canadian Medical Association and argue that this is a position contrary to public interest, that it is not desirable that any institution should have a monopoly over so important a service provided to the people of this country, more particularly in the field of its finance and administration. We have not merely respect for the professional competence of the physician as a physician; we say that organized medicine alone is capable of judging that. But we have strong reservations as to the ability or exclusive ability of the medical profession to determine financial administrative procedures and controls. We cannot see that they have any right to claim exclusive jurisdiction over these aspects of health care, and we have referred to this as a form of medical syndicalism in the brief.

THE CHAIRMAN: Mr. Rabson seemed to have the same notion yesterday afternoon. He did not think that even one medically sponsored group would be the proper ---

MR. ANDRAS: I began to ask myself: Should we call it guild socialism? We call it medical syndicalism. But whatever term you choose to use, Mr. Chairman, we find it objectionable.

We then proceeded, Mr. Chairman, to deal with the submission by the Canadian Health Insurance Association. We have argued that their plans fail to meet the needs of their subscribers in very large measure, that the plans are based on the principle of ability to



MR. CHAIRMAN: Yes. We took up the propo-

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Andras 13002

pay a premium, not on the principle of the requirement to meet a need, and for that reason these plans have been deficient.

We then took up in some detail their proposition for a universal plan for Canada by underwriting the insurance industry, and we have come to the conclusion that such a plan, if implemented, would fail to meet the health care needs of the people of this country, that the plan was narrow in its concepts, confining itself entirely to the services of the physician and leaving out the dentist and other para-medical people.

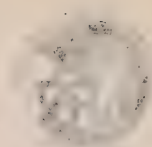
Accordingly, we would like to persuade you that the proposal we have put forward in our original submission should be the one that would commend itself to you.

This, in brief, sir, is our submission.

THE CHAIRMAN: Thank you, Mr. Andras. I have put one or two questions as we went along.

I am interested in the observation that no one group should have a monopoly. What about government?

MR. ANDRAS: We part company on this with the Canadian Medical Association, Mr. Chairman. We cannot accept the principle, if I understood their submission correctly, that government is something removed and remote from the people of this country. We take it for granted that we are living in a democracy, that parliament is a servant of the people and the delegate body that looks after its interests, and we don't consider a monopoly, as the doctors call it, on the



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THE CHAIRMAN: Thank you, Mr. Adams.

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Andras 13003

part of government as something to be equated with the monopoly of a business or a corporation, for example.

THE CHAIRMAN: Or an organization that is part-state and part-industry or part-professional, some co-operative form.

MR. ANDRAS: In that case it would be a question of how the statute has been framed and what has been done. It would be desirable to convert a private agency into a quasi-crown corporation, and then it would become a matter of who controls it, how the consumer interest is represented, how the professional interest is represented, under what regulations this industry is administered.

THE CHAIRMAN: Do you visualize such a co-operative body might be brought into existence due to the drafting of the legislation?

MR. ANDRAS: It is not difficult to visualize it. The papers have been full of it for the last few days, but going by the newspapers reports, which we admit are not as satisfactory as we would like them to be, this is not what we would prefer. The discussions that have taken place and the representations that were made yesterday were in the framework of an insurance principle. There was the question we heard yesterday of risk and adverse selection and insurance coverage. To us, these are not the real issues. We are not concerned with insurance, we do not think we should be concerned with insurance. As far as we are concerned, there are no adverse selections, there are no bad risks; there are simply people in this country who have health



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Andras

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needs, and that is why we would not agree, cheerfully, if I may put it that way, to a proposal of what is essentially an insurance agency to take over the whole of the health services.

THE CHAIRMAN: You put the proposition that health services are a necessity.

MR. ANDRAS: Well, I will put it this way: They should be treated as a utility, made available to the people of this country, without any question of risk or adverse selection. These are principles which may be applicable to houses or cars.

THE CHAIRMAN: Perhaps I might put it in a very personal way. I find it very difficult to move to the utility field in this matter of the personal service of the physician. You can't get him by pulling a switch, if we are talking in the utility field. These are personal services which must be provided, and they can't be provided for in the sense that you conscript an army or even for a short period of time in the case of a flood, as they do across the line, call out the National Guard and that sort of thing to help sandbag the river.

MR. ANDRAS: You pose that as a question?

THE CHAIRMAN: Yes. How do you, accepting the utility concept, then provide service when the state has no right to require the service be given?

MR. ANDRAS: The fact of the matter is that the service exists, we don't start de novo; you have doctors, technicians, nurses of all kinds. This would not become any different. What we have now is a barrier



Andras

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4 between those services and those who provide them and
5 some of the people who need those services. Actually
6 there is more than one barrier, but I will deal with
7 only one. It is the economic barrier which says to
8 a considerable number of people in this country that
9 if you cannot pay the bill, that service is not available
10 to you. Our aim is to remove that direct barrier
11 between the wouldbe patient and the wouldbe provider
12 of the service. This is really the nub; it is how to
13 provide the service, and I think there is complete
14 unanimity that no one should be denied those services.
15 We say that they are being denied those services and
16 that we should eliminate that barrier. There are others,
but they are of a more technical nature.

17 THE CHAIRMAN: Yes, I think we would
18 agree that this is the place where the argument breaks.

19 COMMISSIONER FIRESTONE: Mr. Jodoin,
20 Mr. Andras and gentlemen, I find your supplementary
brief very helpful.

21 May I turn first to paragraph 2 on
22 page 1, in which you refer to the support of the view
23 that you have been putting forward that has been given
24 to you by a number of other organizations, and you
25 say: "...the realization of the objectives just
26 expressed can best be achieved through a public health
27 care program, that is, through a program under government
28 auspices." In looking at the supplementary brief of
29 the Canadian Medical Association, I find that there are
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Andras 13006

for your comments.

The first point they make in their submission in paragraph 4 on page 1 -- and since you haven't a copy of the brief I will read it to you -- the point the C.M.A. makes is: "...the sole control of finances of health and medical services by any single body, be it governmental or otherwise, implies the distinct possibility of complete control of the standard of health care and medical practice. We believe that the welfare of patients, as determined by the quality of care is more likely to be affected adversely where there is only one source of funds for the payment of such services." The argument, as I understand it, is if we had such a program as you have proposed, which is a public health care program under government auspices, the quality of care is likely to be adversely affected, and the medical profession say: "We don't want to provide poor quality care, we want to provide the best possible care."

MR. ANDRAS: I submit that this is simply a question of the value of judgment; it is not substantiated by any evidence.

I remind you of the testimony given yesterday that the quality of care is something that is extremely difficult to measure; it could probably be done over a long period; it would be difficult to do it in a short time. I would be inclined to disagree with that on these grounds: That a great deal of the control of the quality is in the hands of the medical profession itself; any government would have to rely on the advice



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5 think there is any difference in the medical profession's
6 interest in quality and that of the government. I
7 would argue, in any event, that if their profession
8 think they should have buttressed it more fully than
9 they have done, I think the onus was on them to make
10 their case.

11 COMMISSIONER FIRESTONE: The suggestion
12 was that in Saskatchewan in one particular community one
13 doctor had to look after 7,000 people, the other physician
14 had left the community, and because it was impossible
15 for one physician to look after 7,000 people, the
16 quality of care had to suffer.

17 I raised the question whether this
18 was a temporary phenomenon until a new program was
19 put into operation, and the answer I received, as I
20 recall it, was this was not just a temporary situation,
21 that this problem of deterioration of the quality of
22 care would be experienced over a longer period of time.

23 This is the sort of point of view we
24 have encountered. Have you any comments?

25 MR. ANDRAS: I simply say this, that
26 if a community has one physician for 7,000 population,
27 then it is an under-doctored area. This has been
28 happening in many parts of Canada for a long period of
29 time; it isn't a phenomenon that occurred after July,
30 1962, in Saskatchewan.

31 We have suggested in our brief that
32 there are solutions to that problem, that there should
33 be a proper incentive for doctors to locate in under-



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doctored areas. We have told you in an answer at an earlier period that we were opposed to forcing people to locate. This is still our position, but we think it would be possible to get doctors to locate if there were not only incentives but other doctors to locate them.

COMMISSIONER FIRESTONE: Objection was taken to doctors being conscripted to the practice of medicine. The Canadian Medical Association says: "We consider government intervention into the field of prepaid medical care to the point of becoming a monopolistic purchaser of medical services, to be a measure of civil conscription." And further on in that paragraph they conclude by saying that in their opinion it "is contrary to our democratic philosophy". Have you any comments?

MR. ANDRAS: Yes. If there was conscription, we would oppose it. I don't see any evidence that the doctors would be conscripted merely by the universal extension of coverage under a government program. Conscription in this country has a pretty obvious meaning; there is a long history in Canada over conscription, it has a legal and statutory meaning, and if someone thinks that by statute they would be enlisted as soldiers are in the war, I don't think that they would find that this is so.

THE CHAIRMAN: I think we could take out the military connotation that is so widely accepted, as you say.

MR. ANDRAS: I think the term

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THE CHAIRMAN: I think we could take out the military connotation that is so widely accepted, as you say.

MR. ANDRAS: I think the term



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"conscription" connotes a statutory consideration. If our land was in peril because of flood, the government would conscript every able-bodied man, but I don't think there would be conscription in this case.

THE CHAIRMAN: What they are saying is subtly and inevitably -- I am only paraphrasing -- I understood them to say that when the Government becomes the sole purchaser of the service, that the person rendering the service is necessarily compelled to deal with that sole purchaser, and that in a way is the equivalent of being civil conscription. That is what we think they were saying to us, that it is a fact not of saying it in the Statute that you must work for a Government body, but the fact they are being the only one employer, whether you spell it out or not, in fact you have no choice and when you have no choice but to do a thing, in effect that is conscription.

Have I made myself clear?

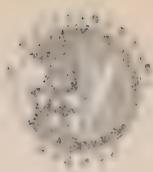
MR. ANDRAS: Yes, I think so. I think what we are taking exception to, probably, is the use of phony terminology because it is used in the public places to distort.

THE CHAIRMAN: We are all inclined to use expressions. Now let us get away from that type of terminology and deal with the issue as I put it to you. Have I put it plainly enough?

MR. ANDRAS: I think you did sir.

THE CHAIRMAN: We will forget the terminology and deal with the issue.

MR. ANDRAS: All right, I would say this,



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THE CHAIRMAN: What they are saving is

subtly and inevitably -- I am only paraphrasing --

the sole purchaser of the service, that the person rendering the service is necessarily compelled to deal with that sole purchaser, and that in a way is the equivalent of being civil conscription. That is what we think they were saying to us, that it is a fact not of saying it in the Statute that you must work for a Government body, but the fact they are being the only one employer, whether you spell it out or not, in fact you have no choice and when you have no choice but to do a thing, in effect that is conscription.

Have I made myself clear?

what we are taking exception to, probably, is the use of phony terminology because it is used in the public places to distort.

THE CHAIRMAN: We are all inclined

to use expressions. Now let us get away from that type of terminology and deal with the issue as I put it to you. Have I put it plainly enough?

MR. ANDRAS: I think you did sir.

THE CHAIRMAN: We will forget the

terminology and deal with the issue.

MR. ANDRAS: All right, I would say this



Andras 13010

if we can use the example of other schemes, British National Health Service is a case in point, I think. The British Act does not require a physician to participate and there are even now a small percentage of doctors who practise freely outside the scheme, and, similarly, there is a small percentage of patients who do not make use of the scheme itself.

The history of the events there show that there was very considerable opposition, as you will recall, by the British Medical Association. When the scheme came into effect, July 5th, 1948, an increasing number of physicians enlisted and participated. Today I think there are some ninety odd percent who are still free to participate or not to participate and it would seem to us that this is an arrangement which is not the essence of conscription, using the word in its loose way.

THE CHAIRMAN: The practice of medicine in Canada and the United States did not develop along the same lines as had been the development in England.

In England there was always a complete and very clear demarkation between the physician and the general practitioner, the general practitioner and the surgeon in that the general practitioner very seldom went near a hospital, that kind of thing. Whereas, the development of medicine on this Continent has been that the general practitioner has, with the surgeon, done most of his work in hospital. You have a different type of development.

In England, starting from about 1911

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at the time of the Lord George scheme the measure of prepayment by a kind of capitation payment for industrial workers, but not for their dependents, had come into being. Then in 1931 that developed to where the dependents were brought in, so that the 1948 agreement seemed to be a logical sequence of 1911 -- 1931 -- 1948.

What you want to do in your suggestion, in Canada, is to forget where the practice of medicine developed, and capsule everything from 1911 to 1948 into one single proposition. Is that right?

MR. ANDRAS: No. With much respect, I would disagree with you sir.

THE CHAIRMAN: That is fair enough.

MR. ANDRAS: You are quite right the British Health scheme, or the National Health Service is really the legitimate descendant of the Lord George legislation of 1911, but you had there a long history of friendly society in the 1880's - 1890's where many doctors who had come to look after a patient were paid perhaps a shilling, in those terrible days.

We have not gone through that stage. That is quite correct. We have gone through another and very interesting and significant development. At the end of the war, or during the war we started with these prepayment organizations, the Blue Cross, P.S.I., commercial carriers and they made a very significant contribution in this country, and in the United States.

THE CHAIRMAN: I would like you to keep this in mind. When Lord Taylor was here I saw him and one of the things he told me was that this development



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of the prepaid schemes, like Blue Cross and P.S.I. and M.S.I. had no footing in England.

That would seem to make a considerable differentiation between the situation in England in 1948 and in Canada in 1962. There had been no forward movement of prepayment from various sources in England. There had been insurance companies operating, but not this non-profit organization which have come to cover such substantial percentage of the population.

MR. ANDRAS: Yes, they do.

THE CHAIRMAN: That condition did not obtain in England.

MR. ANDRAS: We would never think of asking that the program in Canada should be developed precisely along the lines of the British. We have a different kind of country, different form of Government and the development would necessarily have to be different.

Just to take a single example, the very large number of hospitals run by religious orders in Canada make a significant difference in our approach to the provision of hospital care. The existence of these prepayment schemes have done two things; at least they have provided some degree of care -- I use that term advisedly -- for about 60% of the people in this country and we can accept the insurance industry's figures, or the Medical Association's figures. It does not really matter. A significant proportion are covered, to some extent.

Those people are now accustomed to a



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situation where there is no direct economic relationship with the physician. They go to see the Doctor. P.S.I. is a case in point. He is a participating physician. This is all. They never get a bill. The relationship was a perfectly good one. The doctor-patient relationship is good, to the extent that the term is definable.

This is simply an extension from that to a broader, universal coverage in some way and when you saw in this Province the Blue Cross transformed into a universal coverage -- not universal, because it is voluntary in the other Provinces -- where Blue Cross existed, there was a transformation in twenty-four hours. The moment the Lieutenant-Governor signed the Bill, people who had been covered on Blue Cross became covered on a public scheme. There was no dislocation. On the contrary, we obtained for the first time in our lives 100% coverage.

I am simply saying that even these schemes are playing an important role in this country. What we propose is a logical extension of their evolution and development.

THE CHAIRMAN: I may have taken you off your track. You were discussing the development of medicine in England.

MR. ANDRAS: You mentioned other aspects, the business of the physician in Canada practising in a hospital where in Britain there is a rather strong boundary line between the general practitioner and surgeon.

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THE CHAIRMAN: Just as the legal profession



Andras 13014

developed in England in two separate branches.

MR. ANDRAS: You are more competent in that field than I am sir. I will take your word for it.

THE CHAIRMAN: I do not think you are that unknowledgeable.

MR. ANDRAS: Thank you very much. From what I have read of the British set-up, the general practitioner has not taken altogether kindly to the fact that he is barred from the hospital.

In some areas, particularly in the rural areas, he still gets into the hospital. Now in this country we have had a rather different development in the usage of hospitals by the physicians. There is a very great deal of economy within the individual hospitals; you see variation in practice but by and large it is safe to say that general practitioners are able to enter the hospital and follow their patients there.

Then other questions arise of a more technical nature, which we cannot answer, and that is the question of the technical competence of the general practitioner to do in hospital things that perhaps should be done by some one with a greater degree of specialty. This is a matter that the profession is more competent to deal with than we are, obviously.

All we can do is read the literature and see that a controversy exists as to the role of the general practitioner and the specialist, and there is a controversy.

This, incidentally, is one reason why we



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Andras 13015

have suggested a group practice form of medical practice so that there may be a close and intimate relationship to the general practitioner and the specialist working as a team. While it is important to a public program, it is important also in the present framework of medical practice.

THE CHAIRMAN: This is an aside, but many organizations which sponsor, or which support a government scheme say we are very far behind the times because this thing originated in Bismark's Germany.

I have just been told by Dr. Baltzan, who is just back from having a look at some things in Germany, that group practice is forbidden there, in the land where it has originated and was developed. Is that not right?

COMMISSIONER BALTZAN: It is in the Statute. It is in the law in West Germany.

MR. ANDRAS: We must look into the reason for the law. From what we are able to read and observe, and we spend a great deal of time, Mr. Chairman, investigating these matters, we are persuaded that the group practice clinics and health centres across the border are providing what is probably the best kind of medical care that is available in the United States.

THE CHAIRMAN: I am just back from having a look at a couple, and I came back with a tremendous admiration for the way they are handling themselves and their practice.

MR. ANDRAS: I hope you will continue to stay on this side of the border notwithstanding.

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Andras

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COMMISSIONER VAN WART: Following through what we were talking about previously, the transition from the present method of health care with the P.S.I. and so on coming into what you visualize, do you visualize coming into that situation by stages or can you go right into it holus bolus, at once?

MR. ANDRAS: We visualize stages, Dr. Van Wart.

COMMISSIONER VAN WART: Coming into it by stages. Do you visualize retaining the premium system?

MR. ANDRAS: We do not favour the premium system. We would accept it reluctantly if the premium was a relatively small amount, so small as to not constitute a real problem of payment for more than a tiny minority of those who would have to pay a premium.

COMMISSIONER VAN WART: Have you given any consideration to the size of the premium your group could pay?

MR. ANDRAS: No sir, because we are not concerned about our group alone. We were concerned with the people of this Province, of this country and we are aware that a premium is, by its nature, regressive and that any premium, no matter how low, would affect some people adversely.

The answer is if there must be a premium, make it so low as to minimize the effect of it.

COMMISSIONER VAN WART: The premium then would probably be used entirely during the first



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COMMISSIONER VAN WART: Following



Andras 13017

stage, so to speak, and subsequent stages would be above the premium level?

MR. ANDRAS: I do not know. Once a form of payment is entrenched, it is difficult to change.

THE CHAIRMAN: You are either going to have a premium, or tax?

MR. ANDRAS: That is not entirely the case. In British Columbia the hospital program began with a premium payment.

THE CHAIRMAN: Either that or a printing press.

MR. ANDRAS: A printing press?

THE CHAIRMAN: You are going to pay for services. You are going to pay for them either by a premium or from public funds?

MR. ANDRAS: Or from the general revenues, that is right.

THE CHAIRMAN: The general revenues come from taxes?

MR. ANDRAS: That is right. We would prefer that it come from general revenue.

THE CHAIRMAN: Now, your objection to a premium is it is a regressive measure?

MR. ANDRAS: It is.

THE CHAIRMAN: Are taxes not also regressive but necessary?

MR. ANDRAS: There are progressive taxes, Mr. Chairman. We would favour the imposition of progressive taxes, progressive income tax, progressive corporation tax.



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Andras 13018

My colleague, Mr. Bell, is more qualified to deal with that than I am, if you want to direct your questions to him.

THE CHAIRMAN: To your way of thinking progressive means to shift from class A to B?

MR. ANDRAS: On the basis of ability to pay, that is right.

COMMISSIONER FIRESTONE: We come back to the question of civil conscription. I understand the answer you have given is you do not feel that under a government sponsored compulsory plan the medical profession would be subject to civil conscription and, if I understood you correctly, one of the reasons you have mentioned is you do not envisage a plan which would compel doctors to participate in the program.

They can work or practise medicine outside the program. Is that correct?

MR. ANDRAS: That is correct, yes.

COMMISSIONER FIRESTONE: But we heard from the medical profession yesterday when this subject came up, and I raised the question why is this subscription when you are allowed to practise outside the plan, as the physicians are permitted to practise in Saskatchewan, and as I understood the answer it was this is true, but this is a theoretical freedom.

In practice, sooner or later the physicians that want to keep their patients may have to operate under the plan. It is a plan that forces physicians, sooner or later, to work under the plan. As an example we were quoted the experience of the various



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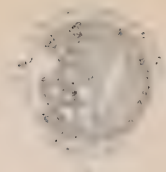
They felt this suggestion that physicians should work outside the plan, except for specialists or very stubborn people, in practice would not work and, therefore, they felt in effect the majority, or a large proportion of physicians would be compelled, either directly or by implication, to participate in the plan. Have you any comments?

MR. ANDRAS: I would say that this argument would suggest that all the present plans be abolished. If this is the effect of it then the P.S.I., the Windsor Medical Service, the North American Life, and everybody else is exercising this kind of compulsion at the present time. The logical thing would seem to be to turn the clock back and go back to the situation where there were no plans.

I do not think that is a feasible suggestion and I am not sure that what the doctors are saying has more than an academic interest. The fact that there is a plan, or not a plan does not stand between the physician and his ability to render a service to his patient. The question of a plan is a method of making the service available.

If he is free to stay in or out, we still submit, whether by implication or otherwise, the element of conscription is absent.

THE CHAIRMAN: What they say is that



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every citizen is required to pay the tax, pay the premium?

MR. ANDRAS: That is right.

THE CHAIRMAN: Therefore, having paid it it is not a practical thing to say then that a doctor is free to not practise within the Act because common sense would indicate that if A was paid a premium to cover the service, he is not going to pay for the service all over again except in very limited cases. In England it is about what?

MR. ANDRAS: Three, four per cent.

THE CHAIRMAN: Two per cent I think is the figure we were given. About one million out of fifty million. If you take the economy of the country, there would not be that same percentage in Canada who is financially independent.

MR. ANDRAS: About five per cent.

THE CHAIRMAN: I am told that those people who have that kind of money just do not give it away either. That is why they have got it.

MR. ANDRAS: This is something worth bearing in mind.

THE CHAIRMAN: To come back to the fact that everybody pays the premium, the tax in various amounts. Some people whose incomes are above the normal might pay \$500., \$600., \$700., \$800. for this coverage in Saskatchewan today, a year. In my own case my salary as judge is a matter of public knowledge. This is in the Statute. It works out to it costs me, on my basic judicial salary, between five and six hundred dollars

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COMMISSIONER BALTZAN: Does the doctor get that?

THE CHAIRMAN: That goes to the fund from which payments are made and it pays for those who cannot pay at all, to keep the premium down, I suppose. You have this universal payment of premium. That act alone, so the doctors say, make this point of saying that because the Act may say that a doctor does not have to practise within it, merely a shadow, not one of substance. That is the thing, I think, the doctors are saying. That is the doctors' position.

MR. ANDRAS: All right, that may be so but I still would say that this is largely academic. This does not face up to the fact there are communities in this Province where this is almost true at the present time, that the coverage by non-profit plans, or by commercial plans, is so universal that most of the people in the community are members, and accordingly, most of the doctors get most of the patients through that source.

THE CHAIRMAN: They are members because they want to be members. They are members, as the doctors say, on a voluntary basis.

MR. ANDRAS: They are covered by group plans provided by an employer, or through a collective bargaining procedure and it is voluntary to the extent that they have collectively engaged themselves in doing so but for people who do not pass through that particular plan, it is part of their conditions of employment. They



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do not exercise an individual choice on the day they hire them. They fall into coverage, as it were, and the physician accepts that. They do not consider it to be a fault, or an impediment to their freedom.

In fact, these plans are very desirable for most physicians. It provides them with patients whose payments are assured. The plan we propose would simply be an extension of that, in a sense. It would still leave those who feel very strongly about it to stay out.

THE CHAIRMAN: When you say that, this is what I am coming back to. You say those who feel very strongly stay out. They stay out and do what?

MR. ANDRAS: They practise medicine.

THE CHAIRMAN: On whom?

MR. ANDRAS: On those who will agree with their terms.

THE CHAIRMAN: If there are any significant numbers left.

MR. ANDRAS: If they want to continue practice.

THE CHAIRMAN: They will either starve or go somewhere else.

MR. ANDRAS: They are free to do that since they have a profession that is universally applicable. It still does not amount to conscription.

THE CHAIRMAN: You are coming back to the use of the word conscription in the sense that you defined it a while ago. We make no progress if we use words that have not the same meaning to both sides.

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MR. ANDRAS: Yes, I agree with you.

THE CHAIRMAN: You see, this freedom then, and this, I think must face Canadians as a nation, if that is so, if there is freedom of choice by the doctor, then his choice may well be he will leave Canada.

In Saskatchewan at the moment he has a greater freedom to go to the other nine provinces. If all ten provinces are the same, would our exodus to the south, where there is already a great magnetic pull, drain personnel of all kinds in Canada? Would they be lured southward?

MR. ANDRAS: We are not sure that there would be such an exodus at all.

THE CHAIRMAN: Take the figures in Saskatchewan, which are probably 20% at the moment of departure.

MR. ANDRAS: I haven't seen any figures, sir. If you say they are that ---

THE CHAIRMAN: We both have our common information from the newspaper sources. That is the figure I have seen published.

MR. JODOIN: Well, I don't know, in a case like this. We have enactment of legislation. I would submit to you right now in Canada, because we don't like legislation, and two provinces in particular, that no work would be done there, simply including surgical instruments, what our technicians do. But I don't believe in that. We believe in the law of discussion, we believe in full coverage in the best way we can do it. If it is a question that we will modify or



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4 go here or there -- I know this great country of ours
5 has a greater population for some years. People come
6 over here, my own ancestors came over here, because they
7 wanted to improve themselves. But I humbly submit to
8 you that we don't use that kind of a trap. It is a
9 question that the law-makers of this country are entitled
10 to have a type of legislation. If we believe they are not
11 good, we hope eventually through changes, democratic
12 procedure, they might be amended. But here we are dealing
13 with human beings and dealing with competence, and I
14 can assure you we know the competence of the physicians
15 in their field, even if we use the income tax as a basis
16 and you count numbers. Well, the population of Canada
17 is not composed of only one segment of our society,
18 everybody is concerned, and that is where the law-makers
19 come in. They are concerned with facing the public, they
20 have to deal with these matters.

21 If we are going on to that type of
22 discussion, we were gradually going that way, that is
23 why I permitted myself to very humbly intervene in this
24 case. I was noting that we were gradually and slowly
25 going to that extent. Again I humbly submit these
26 matters should be abided by once they have been enacted.

27 The submission was made that maybe the
28 Canadian Medical Association would co-operate. It was
29 a little hard to get it out of them; perhaps a dentist
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colleagues and on behalf of our Congress.

COMMISSIONER FIRESTONE: That was a very helpful comment, Mr. Jodoin. Thank you very much.

May I turn to paragraph 24, page 7, of your own brief, where you say:

"It seems quite clear that support for these plans reflects a determination on the part of the organized medical profession not only to control the practice of medicine itself in a professional sense but also the methods whereby the provision of medical service may be financed."

Now, if I can express my own understanding of the point of view that the medical profession has been putting to us, and I stand subject to correction, as I understand it, sir, the medical profession was saying to us: "We are not interested in controlling the method of financing, all we are interested in is that the method of financing be developed in such a way that it enables us to practise medicine effectively and without undue interference." And they went on to say that the best system is multiplicity of systems, and they claim they do not wish to control the method of financing themselves. But they went on to say that if we had a publicly-operated plan, the fact that there is one agency, or if we had ten provincial plans, ten agencies, responsible for the administration of such a plan, then the fact that the plan is handled by one organization, this will lead to the control of the



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practice of medicine, and it is to that kind of thing that the medical profession objects, not because they wish to control the financing but because they are afraid that the people who control the money will control the practice of medicine.

Can I have your views on that?

MR. ANDRAS: Yes. Well, you actually made two points. First you read the sentence of our brief and then you indicated perhaps we were misquoting the Canadian Medical Association's brief.

COMMISSIONER FIRESTONE: By no means. I am giving you my understanding of their position.

MR. ANDRAS: We cited immediately after that a statement by their president. I don't know what their hierarchy is like, but I know when my president says something he speaks for the organization.

In paragraph 26 of our brief we have a statement of the president of the Medical Association which says:

"We in the profession must face these
"issues and act in accordance with our
"beliefs. The prepayment of medical
"care in all its phases -- the collection
"of the funds, the administration and
"the payment for the services -- must
"be more intelligently studied and
"controlled by the profession or it will
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We take that at its face value, and we find that objectionable for the reasons stated.



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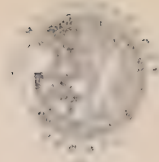
Now, you said that the medical profession says that he who pays the piper calls the tune. There is a great degree of truth in this and we would not argue the point. This is a function of government, to lay down policies. The question then becomes one of definition and degree, and we cannot conceive of a plan of this sort coming into being administered by laymen in a way that would advise a physician how to practise. It seems to us that no public scheme could operate without prior consultation and advice from the medical organizations and other professions in the medical care field.

Now, it is quite true that those who pay have a great deal of power. What we have submitted is that we are not proponents of compulsion in the matter of the medical profession. We have argued in favour of incentive to provide territorial justice, to bring doctors into un-doctored areas, to encourage them to practise in these areas, and so on.

What concerns us as much as the physicians is that there should be ample funds to provide health care which would operate at its optimum. This brings us face to face with the same problem that the medical profession yesterday discussed and on which we take a somewhat different position than they do. We accept the basis that parliament is a sovereign body.

Now, we are not happy with the labour legislation we live under; we hope some day to change it. But we deny the right of any group to flout the sovereignty of parliament or the legislature.

This may not be a satisfactory answer to



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THE CHAIRMAN: That is a very clear exposition of your philosophy in that regard. But coming back to what is the essence of the matter under discussion, this question of the government or any one body providing all the money and therefore on that fact alone exercising control, you say you don't expect that that would happen, although there is a danger.

MR. ANDRAS: It is a question again -- we were talking about the word "conscription" a moment ago.

THE CHAIRMAN: Because it has been represented to us in the factual statement of a young doctor who started to practise in England after 1948 and was very dedicated and full of desire to give the very best care to his patients, and one of his principal jobs as a general practitioner in England is to issue prescriptions; drugs are covered under the British scheme, as you know. He was visited about six months after he began to practise by one of the Treasury officials in the medical district in which he practised, and it was pointed out to him that the amount he was prescribing to his patients was twice or three times as high as Dr. J. down the street, who was an old-timer in the game. Well, he said: "This is the way I have been trained to practise. I have not issued an unnecessary prescription, every one has been needed, and my patients are going to have the very best from me." Well, the official said: "We just came because we want to



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8 said: "Well, if I decide to stay in practice I have to
9 bring myself down to a lower level than what I thought
10 was the best I could give."

11 These are things we have been told.

12 MR. ANDRAS: Well, Mr. Chairman, we
13 don't have to go to England. I was up to see the
14 managing director of one company, and they had physicians
15 on the staff who checked all the invoices -- I shouldn't
16 call them bills from professionals -- for services
17 rendered by physicians, and if the average number of
18 attendances for flu are three and a certain physician
19 submits bills for five attendances for flu, they begin
20 to ask him why his ratio is five where it is three for
21 the most of them. If he does this frequently he finds
22 his relationship with this plan is very tenuous.

23 I am inclined to think that this kind
24 of administrative problem is going to occur under any
25 kind of system where there is any awareness of cost as
26 a factor, and I cannot see any reason why there should
27 be sensitivity as to cost.

28 As to the British scheme, it was
29 discovered that as soon as utilization fees were imposed
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THE CHAIRMAN: What the doctors say is true: This is happening; we fear it more with government. Because, after all, they do control their own program.

MR. JODOIN: It is like the happy medium of profit. Who is right, Dr. J. or Dr. Schweitzer. It is negotiating, collective bargaining. People want to have better profits, people want to have better conditions. Where is the happy medium? Professions have their boards, the bar have their boards. It very seldom happens, but sometimes they have something happen, those who don't behave, the same with the labour movement, and there is a bar that decides whether somebody should be suspended or not. I gather they are sometimes.

THE CHAIRMAN: There has to be discipline.

MR. JODOIN: That is right.

COMMISSIONER FIRESTONE: If I come back to the point of administrative experience in the practice of medicine, and that is the point that doctors have expressed concern about. Could you visualize, or could you and your group have any suggestions, what kind of safeguards that could be developed to take care of this problem? Because you mentioned Dr. J., that this was happening under the doctor-sponsored plans, but in that case an examination is done by fellow physicians, people who know something about the problems that the medical profession faces, that under a government plan presumably this would be done by an administrative agency, and so that the practice of medicine would not be regarded in the same light as it is presently under a



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voluntary system.

Do you not feel that they would be entitled to have certain safeguards to ensure that if they practised medicine they could ensure it would be in the best interest of the country? What kind of things can one think of to take care of the problems that have been put to us?

MR. ANDRAS: There are at least two kinds of safeguards that come to my mind, sir. One is to have strong consultive, advisory committees, representatives of the professional interest, nominated by the profession themselves. The second one would be some form of administrative procedure whereby redress would be sought through some tribunal. We have proposed those in our original submission.

COMMISSIONER FIRESTONE: And you feel that these safeguards would take care of the fears that the medical profession has expressed?

MR. ANDRAS: Well, I can't make any guarantees. Obviously you cannot get one hundred per cent satisfaction.

COMMISSIONER FIRESTONE: Thank you very much, Mr. Andras.

May I turn now to paragraph 37 on page 13 of your brief, in which you refer to some observations made by the Insurance Association:

"It is not possible to designate the
"percentage of Gross National Product
"beyond which government expenditures
"should not go. Obviously, however, if



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very much, Mr. Andras.

May I turn now to paragraph 27 on page 13 of your brief, in which you refer to some observations made by the Insurance Association:

"It is not possible to designate the percentage of Gross National Product beyond which government expenditures should not go. Obviously, however, if



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"governments continue to take an
"increasing percentage of the Gross
"National Product, there will come a
"time when the incentive to strive for
"higher monetary rewards will be
"impaired at many levels of society."

Now, you then proceed, sir, to take
objection to this statement, and may I put the question
to you in a positive way: What are your own views about
the desirability of an increasing proportion of the
Gross National Product to go into health care expenditure?

MR. ANDRAS: I don't think it is a
question of the arithmetical figure, Dr. Firestone. We
know at the present time that there are hundreds of
millions of dollars being expended in Canada for health
care, in a number of ways, by governments, by institutions,
by individuals. We assume that if our program were to
be adopted expenditures would be at least equal to those
already being expended, and there would be even more
money expended. The question then becomes: How far
does one go? Well, we are aware of the fact that in
a great many countries where they have public schemes of
one kind or another the range of expenditure as
a proportion of the Gross National Product is about
five per cent, five and a half per cent. This seems
to be the case regardless of the methods used to provide
care. Now, the five per cent figure, I am not suggesting
that we would commit ourselves to five per cent, but it
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as high as five per cent and six per cent recently. In Great Britain it has been about four per cent. The figures are between three per cent and five per cent. In Canada, in 1953, D.B.S. made a study which indicated a five per cent of national income.

MR. BELL: Could I just supplement those remarks by one observation, Dr. Firestone?

COMMISSIONER FIRESTONE: By all means.

MR. BELL: The idea just occurred to me that a country such as Canada, which has one of the highest G.N.P.'s per capita in the world -- it is quite true that we have slipped behind in the last few years, but we still have one of the highest G.N.P.'s per capita, and it might not be too much to suggest that, therefore, we can afford a higher proportion per capita of G.N.P. for services than many of the other countries which have a much lower per capita G.N.P.

COMMISSIONER FIRESTONE: And the reason is because we are a wealthier nation. Is that the point?

MR. BELL: Yes, exactly. If we believe that these services, health and education, are important, and obviously our Congress does, then we perhaps should spend more than other countries which have a lower G.N.P. per capita.

COMMISSIONER BALTZAN: The three per cent to five per cent for health care services, does this also include research and the maintenance of schools preparing the various professions?

MR. ANDRAS: I don't think it would include schools, Dr. Baltzan. It would include services,



as high as five per cent and six per cent recently. In Great Britain it has been about four per cent. The figures are between three per cent and five per cent. In Canada, in 1958, D.E.S. made a study which indicated a five per cent of national income.

MR. BELL: Could I just supplement

those remarks by one observation, Dr. Finestone? COMMISSIONER FINESTONE: By all means. MR. BELL: The idea just occurred to me that a country such as Canada, which has one of the highest G.N.P.'s per capita in the world -- it is quite true that we have slipped behind in the last few years, but we still have one of the highest G.N.P.'s per capita, and it might not be too much to suggest that, therefore, we can afford a higher proportion per capita of G.N.P. for services than many of the other countries which have a much lower per capita G.N.P.

is because we are a wealthier nation. Is that the point? MR. BELL: Yes, exactly. If we believe

that these services, health and education, are important, and obviously our Congress does, then we perhaps should spend more than other countries which have a lower G.N.P.

COMMISSIONER BALTZAN: The three per cent to five per cent for health care services, does this also include research and the maintenance of schools preparing the various professions?

MR. ANDRAS: I don't think it would include schools, Dr. Baltzan. It would include services,



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direct or indirect.

COMMISSIONER FIRESTONE: I wonder if I could pursue this a little further. Let us assume that Canada were to spend, as a result of a much broader program, over a period of years, larger amounts in absolute terms of National Gross Product. Presumably this would mean more people involved in the health sector; we would have more doctors, more nurses, more dentists who would provide this service, lab technicians, et cetera.

THE CHAIRMAN: Or pay them more.

COMMISSIONER FIRESTONE: Well, you can pay them more. But I think it has been suggested a bit earlier that if we were to extend the plan on a comprehensive basis we would need more people. It isn't only money; we need everything in the health industry, and this includes the professionally trained people, the ancillary personnel and technically trained people, and it is a great variety of people. If we can take the concept of health as an important industry in Canada. Now, increasing expenditures would provide increasing employment in the sector called the health industry. Would you agree?

MR. ANDRAS: Yes, I would think so. Now, in the immediate future there would be great increase in demand, and I think there is a demand now for more people than there are available. I think it becomes a quantitative question of how many. But this would be influenced by the structure of the program itself and the integration among the various practitioners.



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5 COMMISSIONER FIRESTONE: I am not
6 concerned with the quantitative aspect, I am concerned
7 with the direction in which Canada may be moving as a
8 result of a comprehensive health care program for
9 Canada, that is developing stages. We are all realistic
10 enough to say that you can't turn on a tap and have a
11 program overnight, it may be ten, twelve years or even
12 a longer period, but it is the direction in which we
13 are moving and what this means to Canada.

14 Do I understand you to say that
15 increased expenditures would lead to increased employment
16 in this industry call the health industry?

17 MR. ANDRAS: Yes.

18 COMMISSIONER FIRESTONE: The next
19 question I would like to put to you is, if you look at
20 the development of the Canada economy, particularly
21 since the end of the Second World War, have you noticed
22 that there has been a move from the commodity producing
23 industry to the service industry?

24 MR. ANDRAS: Yes.

25 COMMISSIONER FIRESTONE: And therefore
26 would you not feel that if Canada did pursue the policies
27 which would encourage more employment, we may have to
28 do more in the service sector?

29 MR. ANDRAS: Yes; the trend is in this
30 direction.

COMMISSIONER FIRESTONE: If we are to
encourage people into the field of the health industry
and the service sector, that is one which deserves the
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MR. ANDRAS: Yes, sir.

COMMISSIONER FIRESTONE: And therefore can we conclude that the development of a health care program will not only bring more comprehensive health care to the Canadian people as a whole but would also provide increased employment in an area where it is essential, and if we don't provide this, where will we find the jobs for the millions of people we are going to have in the next five years looking for jobs? This is one of the sectors.

Now, can you yourself in your own words, your own views, suggest policies to facilitate this development?

MR. ANDRAS: That trend is as you have already described it Dr. Firestone. There is a very marked trend in the labour forces towards a greater ratio of white-collar employees, so-called, and consequently a lower ratio of manual workers or blue-collar workers.

I want to be perfectly candid with you. Our motive in coming before you was not to seek greater job opportunities for people in the health industry but to provide health care for the Canadian people. However, we will not look a gift horse in the mouth. If there are greater employment opportunities in the health field, we will be glad to see them there.

Now as to how to obtain that, this is a far more complicated question to answer because this involves our whole educational system, and our whole concept of motives and incentives of impelling or



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To take a concrete example, at the present time we are short of dentists in Canada. The ratio of population to dentists is very high, it appears. Judging from what the Canadian Dental Association says, there should be more dental colleges, at least two, if I remember correctly. I understand it would take about twelve years from the time the plan begins for a dental college until the first student graduates from it. If I am wrong, a year or so your own expert on the Commission can contradict or reply.

By and large, it is a long term process. If we are going to get more dentists, we would have to start very soon to take these steps. We would have to make it possible for the would-be dentists to get started. If there is an economic barrier between the would-be dentist and dentistry, we should eliminate that barrier. If there is a barrier in the lack of seats in the lecture hall, that barrier has to be removed.

The same applies to other professions. I do not have to name all the professions. There are scores of them nowadays in the health field. We have to have a more advanced procedure of vocational guidance. We have to have more educational institutions. In some instances higher financial returns and a combination of all these factors to persuade people that their future lies in the health industry. Not every one who enters the health industry has a vocation for it. Some do. The doctors, the dentists, the nurses. To some it is simply



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a way of making a living. If it is making a poorer living than some other alternative employment, they will not enter the health field. Some of the difficulties used to be encountered in the hospitals with regard to the high turnover of staff due to poor working conditions. This has improved to a great degree.

I make that comment to illustrate what can be done to attract people in the first instance, and then having got them, to retain them in this particular industry. I am not suggesting, by any means, this can be done in one week. It is a long haul but it requires some planning and consideration in advance and this is one of the points we have tried to make to you.

COMMISSIONER VAN WART: That applies to every system you bring in does it not? Whether it is your system or an extension of the insurance scheme, these things have a sort of parallel. Would you feel that or not?

MR. ANDRAS: I would have to say the answer is yes and no. The answer is yes to the fact there are shortages right now with dental nurse, various kinds of doctors, some kinds of technicians, para-medical personnel, and so on. We should be trying to fill the shortages.

The other thing is that an extension of the private schemes, by itself, would leave the status quo pretty much in touch, regarding the supply to be filled on the part of the labour market. We contemplate a situation in which there should be effective



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co-ordination of the services so as to obtain maximum utilization of those providing services. It is our feeling that an appropriate division of labour as between practitioners and their effective teamwork can do a good deal to remedying the shortage of supply. This is why I said it was a yes or no answer.

COMMISSIONER VAN WART: You would mean the two would develop side by side?

MR. ANDRAS: We think that planning for personnel may be complimentary to the program we propose.

COMMISSIONER FIRESTONE: That is a very helpful answer. It really sums up, in essence, what I have been driving at. What you are really saying, Mr. Andras, is you are not talking only in terms of a program that will provide for increased expenditures, but should also provide the manpower and the facilities to implement that program?

MR. ANDRAS: We would say this is a sine qua non of a public health care program.

COMMISSIONER FIRESTONE: You use the word planning for them. On the demand side providing for the services, and the finances, and the supply side it involves facilities, et cetera. Do you have in mind a continuous planning process that might be put into effect by Government or Governments because, as you rightly said, nothing can be achieved overnight. The program may have to be changed, revised, co-ordinated, altered. How would you go about this planning?

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For example, the population projections in Canada are made on at least three assumptions. On fertility or growth of population, not necessarily only by fertility alone, of course, so that there needs to be constant revision as the facts and the projections come head on.

The Canadian Medical Association, for example, has given you projections up to 1970 on their requirements for physicians. This is based, again, on certain assumptions. These assumptions must always be subject to consideration and correction, so that planning itself is not a one shot affair. It must go on constantly.

COMMISSIONER FIRESTONE: This planning you are talking about, you have in mind just the status as the result of the planning process, or do you consider this planning to go further? You will be offering the advice to Government, to a decision-making Government. You mean planning in this broader sense or narrower sense?

MR. ANDRAS: We think of planning pretty much as a broad process. We think the planners, whether they are government or a group of advisers would have to plan in a large framework and obviously, a great deal of action would have to come from the Government end; the one that is going to provide the resources, the capital needs for schools and hospitals, or research



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facilities. These require large sums of money, and obviously if you are going to plan for these things you have to plan on a long term basis.

COMMISSIONER FIRESTONE: The planning would cover not only the status of the investigation, the preparation of reports and memoranda and consultation among the professions, and other groups, but also advise Government as to enable Government to make decisions. Is it planning in that sense?

MR. ANDRAS: Planning connotes implementation.

COMMISSIONER FIRESTONE: I am just trying to get planning defined. I know planning connotes many things to many people.

MR. ANDRAS: No. It involves much more than mere consultation or seeking advice. It implies advisory procedures and then carrying them out, if they seem to be reasonable and logical.

COMMISSIONER FIRESTONE: Now how would this planning be done? Are you outlining a health care planning agency within the Federal Government service, within the ten Provincial Government services or a Federal-Provincial body or a co-operative body or advisory council or a Dominion-Provincial conference. How do you visualize this planning function to be performed?

MR. ANDRAS: We have no policy statement on that. You are asking me a question and you want an answer and I will try to give you one.

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MR. ANDRAS: It would seem to me that in a country like this, which has the decentralized form of Government, planning must take place on more than one level. I would visualize some planning agency at the Federal level. I would visualize further planning at the Provincial level.

I would consider it essential that there be a Dominion-Provincial co-operation because of their inter-dependence. I would carry it further and say that planning would by necessity have to involve the professional interest and the consumer interest so that everybody would be involved in the planning process itself.

In other words, the business of planning would be a rather complex affair, at best.

COMMISSIONER FIRESTONE: This has been most helpful because you have suggested to us that planning, if it is to take place, should take account of our constitutional division of responsibility. It should take place on two levels and should have representatives of all the major interested groups?

MR. ANDRAS: That is right.

COMMISSIONER FIRESTONE: And then, presumably, the result of this planning would be advice given from the planning agency to the respective levels of Government, and then there would be consultation between the Governments. A Federal-Provincial conference on health program, is that what you visualize?

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8 by Statute, and in that instance, in this particular
9 example it would seem that has gone beyond the stage
10 of a Dominion-Provincial conference. In the case of
11 grant-in-aid for the other aspects of health care, some
12 such conference might be necessary. On the other
13 hand, it might be a case of the Federal Government simply
14 saying to the Provinces if you will introduce a program
15 and you will provide at least so many kinds of services,
16 then we will take such and such proportion of it and
17 then leave it to the Provinces within their jurisdictional
18 competence to evolve the program for their Province
19 alone.

20 COMMISSIONER FIRESTONE: If the
21 Federal Government would do any planning on its own, it
22 presumably will wish to consult the interested parties.
23 You mentioned the medical profession, and, presumably,
24 they will want to take account of different regional
25 requirements, of which the Provinces, presumably, are
26 best informed?

27 MR. ANDRAS: That is right.

28 COMMISSIONER FIRESTONE: How do you tie
29 in an act with the Province, with the Federal Government
30 with this planning process?

MR. ANDRAS: It is being done in other
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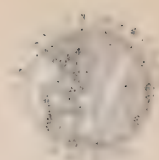
COMMISSIONER FIRESTONE: Your suggestion
is it be done on a formal or informal basis, as conditions
make it desirable?

MR. ANDRAS: It would most likely be
the former basis, though we can conduct it on an informal
consultation basis. You probably know that much better
than I do.

COMMISSIONER FIRESTONE: Thank you for
your observations on this point. Two more questions,
sir. One is what is the view of the Canadian Congress
of Labour on the Medical Care arrangements as they are
now in operation in Saskatchewan? Do you approve of
the arrangement?

MR. ANDRAS: Well now, I must sit back
and think about that, Dr. Firestone. We cannot say that
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represents a compromise between two parties, who, before
that compromise, were engaged in a head-on battle. There
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Now a yielding or a compromise is the
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to say to you.

Secondly, we approve of it to this extent: That it has provided for universal coverage. To us this is an essential principle.

Thirdly, we approve that it has provided or is providing a fairly wide range of medical services, plus the services of therapists to the people of the Province. In the connotation of the private plan, it would be a comprehensive plan, if it were a private plan. These we consider desirable.

As we read the legislation, it seems to leave room for expansion into other fields of health care. To this extent we approve of the Saskatchewan Medical Care Insurance Act.

COMMISSIONER FIRESTONE: Thank you. My last question refers to something that has come up a little earlier when the Chairman raised the question of the Provincial Government using a voluntary agency like P.S.I. or M.S.I. to administer medical care plans. Do I understand that you have objections, or you have no objections to such an arrangement providing that this is a comprehensive plan and the agency acts as the administrative arm for the Provincial Government?

MR. ANDRAS: Well we object to it on various grounds. One is that it still leaves the problems to a private agency now, as to the problem of means testing or a coverage nature; that the range of services in any of these plans is confined, by and large, to the services of the physician. That is not entirely true because the major medical provides additional services.



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I am talking of the plans which appeal to most people at the present time.

THE CHAIRMAN: Assuming that it would be an expansion to meet your wishes, in that regard we are talking of the future and I know you cannot divorce it entirely from the present, but we are talking of what might be in the future; that would be in terms of coverage as we want it in the future as well. You cannot talk of the future and relate it to present coverage and condemn it because of the present coverage. Do you see what I mean?

MR. ANDRAS: Yes. In other words, you are saying let us suppose it provides all the services we want?

THE CHAIRMAN: Yes.

MR. ANDRAS: All right. Frankly, I do not think they are equipped to do it but let us assume for the sake of argument they can.

THE CHAIRMAN: Why is a group that might be so chosen not equipped to do it when another one solely because they are appointed by Government would be equipped to do it?

MR. ANDRAS: Because these private plans came in as the creatures of particular interests, P.S.I. or M.S.I. or G.M.A., whatever ones you want. They came into being through the efforts of the medical profession.

THE CHAIRMAN: You want to continue to look at them as they were before and not as reformed for the future?

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to look at them as they were before and not as reformed for the future?



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MR. ANDRAS: Once they are going to be reformed, we do not see any future in the perpetuation of what is essentially a private plan. It might just as well be turned into a Department or a Commission of Government, and in that case be subject to the influences and the control of the people who are paying the bill.

THE CHAIRMAN: And the party politics involved?

MR. ANDRAS: Mr. Chairman, we have no exception, except in quality, to party politics. We consider that to be a natural part of life in a democracy. We consider the politician the most adept and skilled practitioner in our Society.

It is not a question of the Government practitioner. They render an extremely valuable service.

THE CHAIRMAN: Now you are talking of the future.

MR. ANDRAS: Politics happens to be our way of life. We would not have it any other way sir.

COMMISSIONER FIRESTONE: Thank you for those comments, Mr. Andras. May I come back again to the question I asked. What I am trying to establish is, assuming that the Provincial Government decides to proceed with a comprehensive plan of medical care along the lines that you have suggested and they say to themselves now what is the most efficient way of implementing the plan?

They may then say why here is a group of people who have done some of the work, or a great deal of the work. They have had a lot of experience. Why not

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turn this administration of the plan over to them and ask them to expand their facilities and do certain control procedures to safeguard the public interest? They would put that program into effect in a comparatively short period of time, rather than have to build up a staff, train them and take weeks, months or years, perhaps, to have an efficiently operating system. What are your objections?

MR. ANDRAS: Two points. The first is that the staff, the administrative staff, and so on, are oriented. They have developed loyalties towards the group who brought them into being. This is important, the question of motives is very important to us.

THE CHAIRMAN: Just on that point, I do not want you to lose the question, but in Saskatchewan they offered employment to all those people. They said they would take over all employees of the private plan.

MR. ANDRAS: And they would then become public employees.

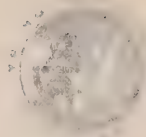
THE CHAIRMAN: By doing that, do you suggest that would change their training and orientation?

MR. ANDRAS: No. Not their training.

THE CHAIRMAN: But their motives?

MR. ANDRAS: Yes. I think it would create a change in motives.

COMMISSIONER FIRESTONE: Now, can we understand my question correctly, sir, and please ascribe it to my inadequacy in presenting the question if I did not make it quite clear. What I have in mind is a Provincial Government coming to this association and



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Andras

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saying you people have been in the business, if you want to take over holus bolus you become all public servants, be subject to certain controls but run the scheme for us, putting in certain safeguards. That is what we are talking about.

MR. ANDRAS: This can be done.

COMMISSIONER FIRESTONE: You do not have any objection in principle to using existing facilities that can be built up as a result of medically sponsored efforts?

MR. ANDRAS: If you are suggesting simply a take-over of personnel or ---

COMMISSIONER FIRESTONE: Or organization more than people. Let us call it organization so that we do not get involved in quibbling on words.

MR. ANDRAS: We are bound to quibble about words. In any event, in Ontario the Government did, in effect, take over the personnel of Blue Cross and they left Blue Cross behind them with a shattered body, in terms of the people who used to run it.

Now, this obviously can be done. What we are concerned about is where the control lies, and whose interest is being served. Now, what you have described to me becomes very much a quasi public institution. It begins as a private agency, it might continue under a private charter, but it would certainly become, at the very least, a quasi public institution. There are such institutions right now.

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COMMISSIONER FIRESTONE: That is what

we are talking about, whether we can envisage a system of



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quasi public institutions that is subject to control and still give them, the medical profession, the feeling that they are not all, like one doctor suggested, civil servants.

MR. ANDRAS: As a former civil servant, I am sure that does not fill you with horror.

COMMISSIONER FIRESTONE: It is not my attitude which is important. It is how the doctors feel. They are the people who are going to look after the patients in Canada.

MR. ANDRAS: We said in our brief, Dr. Firestone, that there are many divisions of administration. There are many forms of commission. For example, if it is, say, a question of administrative procedure or method, we would be quite prepared then, as the doctors are, to sit down and examine the alternatives. We are not wed by dogma to any particular method of administrative program.

COMMISSIONER FIRESTONE: That is a very helpful answer. Thank you very much.

COMMISSIONER BALTZAN: This has been a very fruitful discussion this morning. Thank you very much. I have only one question to put to you. It is not a question of size. My question is how urgent is universal comprehensive medical services required in Canada at present and how immediate?

MR. ANDRAS: My President says tomorrow morning, and what the President says goes, Dr. Baltzan.

COMMISSIONER BALTZAN: I accept that. I am basing this question on some things that have been



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4 said about there being a need, because there is a
5 deficiency, because we have not got a scheme and,
6 therefore, other nations that have a scheme are said to
7 be better off. Do you subscribe to that?

8 MR. ANDRAS: Better off has a wide
9 application. I do not know. To the extent that there are
10 people in this country who cannot get the use of a
11 doctor or dentist or nurse when they need it, then we
12 are not well off and this means that the sooner we
13 impose measures to provide those services, the better
14 off we will be.

15 COMMISSIONER BALTZAN: You are thinking
16 in terms of improvement. In the same position then, in
17 relation to the total coverage, et cetera, when one is
18 thinking of our economic and implementation of things,
19 one thinks in terms of which is most urgent. Are there
20 certain priorities before us? You take total coverage,
21 must we begin to look at implementation of certain things
22 that are really deficits in our operative procedures in
23 the health scheme?

24 MR. ANDRAS: One faces a problem here
25 that there are deficits in a number of areas. In
26 practical terms we could not meet these deficits all
27 at the same time. We have indicated in our brief that
28 one of the deficits that need not be looked after at
29 once would be dental care.

30 We suggested this might have to be
given a second rank in the order of priority, not because
it is not important, but because of the lack of personnel.
Our feeling was the first step should include the services



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of the physician. That is, all grades of physicians.

COMMISSIONER BALTZAN: You do subscribe to the idea that those things that are said to be required first must come first?

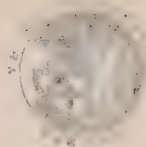
MR. ANDRAS: We think dental care should come first. Unfortunately it could not because of the current situation. If there is to be a two phase or three phase program, if priorities are to be suggested, and we have ourselves suggested them, our first order of priority is the medical practitioner.

We have suggested two or three other things. They are in the brief there.

COMMISSIONER BALTZAN: Thank you. I think that answers my question.

THE CHAIRMAN: Why do you say that the first priority is the medical practitioner, rather than, say, rehabilitation, mental health or retarded children? These are all areas in which, we must admit to ourselves, that we lag, lag in the sense that we would like to see things better.

MR. ANDRAS: Well it is a difficult question to answer. We would never suggest to you that we are not concerned about the problem of retarded, for example, or mental health. We are concerned about this fact that illness is unpredictable. We know that it exists, and in a considerable quantity, and that there are people who need medical services, whether physical or mental, acute or chronic. From what we can observe a very major forward step would be taken if all the people in this country had available to them, or had



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made available to them the services of the medical practitioner. This would not solve the problem of rehabilitation or mental retardation overnight.

Retardation involves more than a medical practitioner. You have got the vocational teacher, you have got the social service worker, many others we are constantly confronted with.

This is what makes the question so difficult.

THE CHAIRMAN: If I may put it as fairly as I can in this way: By reason of the public debate which has gone on over providing for the cost of medical services, is there not some notion abroad that if we do accept your first priority, and provide for the payment of medical services, and make them available, that we will then be almost at the millennium, or something like this.

This is a notion that has been made current by many people, not from any one party, in this whole public debate; the providing of medical services will move us into the forefront of everything.

MR. ANDRAS: No sir. It would simply begin to point up almost instantly the other gaps that exist in the field of health care.

THE CHAIRMAN: Have you not felt yourself that the accent which has been put, in the public debate, on the payment of the medical services has served to sort of push into the background these other equally important phases of health services?

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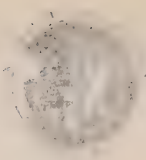
the word "equal" is a term to use. We would be concerned with a public health program.

THE CHAIRMAN: That is a matter of judgment. I might think to have medical services was not equal to looking after the thousands of mentally ill people in Canada who are housed in varying degrees of inferior places, and to the hundreds, and so forth, retarded children and crippled children, and that kind of thing.

Perhaps the first area ought to be, our first concern ought to be in those areas rather than in the area in which, regardless of what our comparative position may be in the world, is certainly in the top bracket in terms of providing medical services.

MR. ANDRAS: It is hard to quarrel with you, and I would not want to, Mr. Chairman. We do not take, as I said, important objections. In the case of mental health, this is a major Canadian problem. Half our beds are full of mental patients. This is partially a medical problem. It is partially an institutional problem, the way in which we approach mental illness and I am inclined to think this country is undergoing a major revolution in its attitude to its approach to mental health. This is taking place even now.

THE CHAIRMAN: What concerns me is if we use the money available, the resources are not unlimited and we can only appropriate "X" dollars, whether it is six per cent or seven per cent or even ten per cent of G.N.P. We have only "X" dollars to appropriate to this area of activity and if we exhaust ourselves and use all our resources in this one area of providing medical



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care, and pay for it, we have nothing left to look after the mentally ill, the retarded, and so forth, et cetera.

Ought we not to have a very good look at this question of priorities and question whether your number one priority should in fact be the number one?

MR. ANDRAS: That is a moot point. I think our number one priority would make available a service to the maximum number of people. Now if it is a reasonable priority, we would subscribe to it.

I would make a further point, that it is not as though no attention were being paid to mental health. A great deal of attention is being given to it, and, in fact, this so-called Saskatchewan plan -- these smaller mental health care institutions are relating the mental health wards to the general hospital. All this is beginning to take place.

THE CHAIRMAN: In Holland and perhaps around Manchester was where the thing originated.

MR. ANDRAS: Let me give the credit to my favourite province.

THE CHAIRMAN: We have no desire in Saskatchewan to hog all the credit.

MR. ANDRAS: What I was trying to say is this is not as though no priority had already been given to mental health. I think there is an increasing priority which has already been given to it.

You used mental retardation as a problem. I am inclined to agree with you that this has been an area of gross neglect. I cannot use any politer words to describe the situation in which parents have been



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THE CHAIRMAN: The credit goes to the credit.

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placed, and I think it is almost a scandal that this should have occurred.

I am glad to say that the situation is changing. The question of priorities becomes not only one of order of priorities but of quantum, and you then have a combination of order and quantum, and this is the kind of thing one has to sit down and examine more carefully than we are able to do in this kind of transaction.

THE CHAIRMAN: We appreciate it is a problem we have to face very, very soon and very seriously.

MR. ANDRAS: Yes, we understand quite well.

COMMISSIONER VAN WART: One question along a different line, a sort of principle. We have been hearing that the nearer you keep to lower levels of administration, a municipality or parish, and so on, you get more personal service in administration than you would with a federal, impersonal administration. Do you see any advantage in having a closer personal contact with the administration?

MR. ANDRAS: There are two answers to that, Dr. Van Wart. One is that we have favoured a decentralization. We haven't spelled it out to what level, and it descends, but we have favoured a decentralized administration. We haven't visualized a highly centralized administration from Ottawa.

The second thing is that decentralization or personal contact of itself is not enough, it is a



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question that the quality of the administration counts as well. Unless you have competent administration, no matter how personal it becomes, it is no good.

COMMISSIONER BALTZAN: Mr. Andras, I would like to come back for the record's sake, because I was trying to recall the figures at the back of my mind. It has been said that 8% of the population do receive free medical care, and then there is 16% that are unable to pay, some of the time, so the balance is 76% who are apparently able to pay and apparently able to get the services if the services are available.

With that background, how urgent is a universal comprehensive scheme necessary when, added to what the Chairman has said, one has to take into account the question of the economy and the matter of the priorities in the medical field and in the national field?

MR. ANDRAS: I should say with respect that you should not take the C.M.A. figures at face value. They are saying that 8% are indigent, another 16% need some assistance, and they then jump to the conclusion that the others are able to pay. We don't know that that is the case. We don't know what domestic economies people have to make to do so. We don't know whether they prefer to do without than to submit themselves to a means test. These are questions that the C.M.A. have not answered, and we are not too happy to take these figures at their face value because these questions have not been answered.

THE CHAIRMAN: Have you any counter



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I would like to come back for the record's sake, because I was trying to recall the figures at the end of my mind. It has been said that 85 of the population do not have three medical years, and then there are 15 that are unable to pay, some of the time, so the balance is 100 who are apparently able to pay and apparently able to get the services if the services are available. With that background, how urgent is a universal comprehensive scheme necessary when, added to what the Chairman has said, one has to take into account the question of the economy and the matter of the services in the medical field and in the national

Mr. Chairman: I should say with respect

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THE CHAIRMAN: Have you any counter



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figures?

MR. ANDRAS: No, because we are not interested in counter figures; we are interested in the application of a program without means test, and if people are going to pay ---

THE CHAIRMAN: If you had the facilities for giving us adequate figures, you would not withhold them?

MR. ANDRAS: No, sir.

THE CHAIRMAN: Have you the facilities to give us figures, what you call more accurate figures?

MR. ANDRAS: I would have to ask my colleagues that.

THE CHAIRMAN: You see, as we have mentioned a number of times, compromise is the great essential in arriving at many decisions, and this Commission may find itself compromising. I find myself compromising in my own thoughts.

MR. ANDRAS: We will give you two answers to that. One, we will examine the data available and see if we can provide the figures; and, secondly, we suggest that your highly-trained men examine the figures given by others to the same degree you will examine ours.

THE CHAIRMAN: Oh, indeed. I don't accept it as a compliment at all. I don't accept too much I either read or I am told too much at its face value, I have to look into it.

Gentlemen, I want to thank you most sincerely on my own behalf and on behalf of the members



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of the Commission for your attendance here this morning, for your submission and for the frankness of the discussion and the way you have answered without reservation. This type of discussion is bound to be of assistance to us. I think anybody would be wrong who thought that from the nature of the questioning the questions necessarily come from a decided position. We are being provocative intentionally. We are grateful to you for having accepted this type of interrogation.

MR. ANDRAS: We consider it a pleasure, sir.

MR. JODOIN: Mr. Chairman, members of the Commission, we would like you to accept our appreciation of, let us say, a sympathetic hearing of our submissions. We know that these submissions will be considered. May I humbly submit that we hope that the suggestions contained in those submissions will be implemented in your report.

THE SECRETARY: Mr. Chairman, the next submission is The Board of Examiners in Optometry, Province of Ontario. Mr. Baker will present his group, and the exhibit will be known as R-8.

---EXHIBIT NO. R-8:

Rebuttal and Supplementary
Submission of the Board
of Examiners in Optometry,
Province of Ontario.



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

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REBUTTAL AND SUPPLEMENTARY SUBMISSION

to

A BRIEF

to the

ROYAL COMMISSION ON HEALTH SERVICES

Submitted by

THE BOARD OF EXAMINERS IN OPTOMETRY

PROVINCE OF ONTARIO

APPEARANCES

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I. BASIC FACTORS IN PROVIDING ADEQUATE VISION CARE

1. The Board of Examiners in Optometry for the Province of Ontario is grateful for the opportunity of presenting this supplementary brief. It has studied with interest many of the submissions and transcripts of hearings by the Royal Commission on Health Services. From these it is evident that health care in Canada is a gigantic enterprise made up of many parts and showing great diversity in its forms and functions.
2. These studies have helped the Board to a better understanding of its own problems. In addition they have allowed the Board to gain a better insight into the magnitude and complexities of those confronting the Commission.
3. This brief is presented for two reasons. First, it provides an opportunity to make additional comments and to voice opinions concerning some aspects of health care which have been discussed in these investigations. Second, it affords an opportunity to reply to statements made in other briefs and hearings which, it is felt, require further elaboration, clarification and in certain instances direct rebuttal.
4. From the submissions before the Commission concerning the needs and requirements in the field of vision care, it has become apparent to the Board that there are three major areas which require investigation and solution, if the future needs of the public for vision services are to be met satisfactorily.



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5. Briefly, these areas deal with the shortages which are presently becoming apparent, the limitations in financing professional education for the increased numbers of optometrists required, and certain developments which are rapidly taking place in regard to prepaid comprehensive health care plans.

6. In order to view these major areas in their proper perspective, it is necessary to review briefly the pertinent facts relating to the need for and the use made of the personnel who are presently providing vision care for the public.

7. As has been shown in the original optometrical submissions, the extent of the utilization of vision services by the public is great. At least half of the population requires such services and 40 percent of the population uses them regularly.

8. These services are provided by two gr-ups, optometrists and ophthalmologists. As reported in the brief of the Canadian Association of Optometrists, 65 percent of vision care (Vision care includes examination, refraction, prescribing, treatment except by means of drugs and surgery, and fitting the appropriate optical devices. In the case of Optometry, this care is carried out as a single unified service; in the case of Ophthalmology, the service is divided between the ophthalmologists and some 500 opticians). is provided by 1411 optometrists. The remainder is provided by the equivalent of 470 ophthalmologists.

9. At the present time the numbers of optometrists and ophthalmologists who graduate each



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year do little more than replace the numbers in each group which are lost through processes of attrition. In the face of the rapidly increasing population this situation, if it remains unchanged, will lead to serious shortages in the numbers of practitioners needed to provide these vital services.

10. It is also clear from this that there is no duplication of services. Sometimes it is suggested that the existence of the two professions, optometry and ophthalmology, results in the duplication of the same service. This has no basis in view of the manner in which these two groups are presently distributed and share the total service. Each is essential and indispensable to the whole.

LIMITATIONS OF PRESENT TRAINING FACILITIES - OPTOMETRY

11. In that part of the Board's brief which dealt with the existing training facilities for optometrists, it was pointed out that the College of Optometry of Ontario had facilities for graduating not more than 20 to 25 optometrists each year, a number which does not contribute adequately to the future needs.

12. This limitation results from the fact that the physical facilities and teaching personnel are maintained by limited funds, provided by the optometrists of Ontario. It was shown that the present teaching facilities and personnel can not be significantly expanded without expenditures beyond the capacity of this group of optometrists to provide.



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13. The Board feels that this limitation in the College's facilities for graduating sufficient numbers of optometrists, is of primary importance to the Commission, for it is fundamental to the problem of providing for the future needs for vision services. At the moment, there are a number of young men and women whose applications for admittance to the College have not been accepted because of these limited facilities. In the face of the pending shortages, the Board is naturally concerned about this.

14. Arising out of these considerations of the limited facilities of the College to train optometrists to help meet the future need, the Board in its first submission has, by way of solution, suggested that optometrical education be given in the University. In this way several benefits would be derived; the College could utilize the greater facilities of the University for training in the basic sciences and in the other requirements of its curriculum; the College would be assured of adequate graduate training programs and research facilities that are essential to providing high standards of training; and optometrical education in Ontario could be aided by means of the usual methods of government subsidization through the University.

THE IMPACT OF PRE-PAID MEDICAL PROGRAMS

15. By its actions the public has demonstrated its preference for pre-paid comprehensive health care coverage, and as a result there are now in existence a number of pre-paid comprehensive medical plans.



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In view of the present situation, there seems every probability that such plans will increase.

16. This development which has been taking place rapidly and which, coupled as it has been with a rising standard of living and large increases in population, is having considerable effect upon all health services and the professions which render them.

17. Such plans have brought into existence new, large, third-party organizations. As it happens, these organizations have, inherent in their function of mediating between the people and the professions, powers to influence or control, to stimulate or depress, any or all services, groups and professions, which operate in this field. This control is accomplished either directly by regulations within the program, or indirectly by the exclusion of some services and practitioners from the plan. Such forces can have a decided effect either for better or worse on the quality and quantity of health services that will be offered in the future.

18. Generally speaking, the values of such plans are obvious as is indicated by their acceptance by the public. However, in the case of vision care, such plans as they presently operate are limited, misleading and in the long run harmful.

19. They are limited in several ways. In the first place, most of them do not include vision care services and in those which do, the services of optometrists are for the most part excluded. This means, of course, that only part of the public can have



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vision care services under such plans, since there are insufficient numbers of ophthalmologists to perform even one half the work, let alone the whole of it. It is in this sense that they are misleading. As well as this, they are misleading since there are in Canada today many people who, though they have paid for vision care services in a prepaid comprehensive medical plan, obtain nothing in return because there is no readily available ophthalmological service.

20. These plans are harmful because they do not and can not meet the public's needs for vision services, because of the limitations in the numbers of ophthalmologists, and at the same time they constitute, an unwarranted and restrictive influence on other services. That is, they depress the normal development of other factors in this field, that are needed to assure the adequacy of future services. They are harmful to optometry. They cause misunderstanding and interfere generally with the normal relationship between the optometrist and his patient. They create currents of referral and management of practice that work against the interests of optometry. These developments cause real problems for the profession of optometry and for the Board.

21. As matters stand at the moment, and in spite of the efforts that have been made to correct the situation, no overall solution has been arrived at yet. It is interesting to note that some legislatures such as those of the Province of New Brunswick and the State of New York have seen fit to pass legislation



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which safeguards the right of the patient to select the vision care practitioner of his choice.

22. The Board, while it is specifically charged with, according to the Optometry Act, the responsibilities of licensing, disciplining, and training optometrists, as well as with the protection of the public in matters pertaining to optometry, recognizes that these things in themselves cannot be considered in isolation from the more general aspects of vision and other health services.

23. There is a multiplicity of groups and factors which are inextricably interwoven in the fabric of our system of health care. This system has evolved in an orderly fashion over a considerable period of time in response to public need. While the Board recognizes that some of the Commission's problems are made more complex by this characteristic of multiplicity and the segmental nature of the services, it also believes that this system has produced in the long run, more services relevant to the needs, more trained men, better qualifications, more incentive and possibilities for fulfillment, as assuredly it has given a better distribution of practitioners. More so in fact, than if it had been subject to a central discipline and a tighter control. This the Board feels is particularly so in the field of vision care.

24. This is not to say, however, that it feels that the parts should not be, or could not be better integrated than they are, or better co-ordinated, or



which safeguards the right of the patient to select the vision care practitioner of his choice.

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that the government should bear no responsibility in guiding and nurturing and balancing the related parts. In fact such guidance and leadership is essential if high standards of health care are to prevail in Canada.

II FACTS ABOUT OPTOMETRY - A REBUTTAL

25. A number of submissions have been made to the Royal Commission on Health Services by optometrical representatives (1, 2, 3,) concerning the nature of the services provided by optometrists and the extent of their utilization, the qualifications of optometrists, their training and their mode of entry into practice. During the course of the hearings in Toronto, a number of remarks were made in response to questions by the Commission (4, 5, 6,) which seem in contradiction to the facts presented by optometry's representatives. The Board of Examiners in Optometry for the Province of Ontario, under the provisions of the Optometry Act (RSO 1950), are responsible not only for the operation of the College of Optometry but also for controlling entry into the practice of optometry in Ontario, and disciplining optometrists in accordance with the statutes and regulations. The Board is concerned to ensure that the Commission shall have no doubt as to the accuracy of their submission and the nature of the role which optometry has played and will play in the provision of health care to the people of Canada. It is the purpose of this section to clarify any misconceptions or ambiguities which

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(Annex)

FACTS ABOUT OTOMOTRY - A REPLY

11

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may have arisen from previous presentations.

26. Dr. Hannah (7) in a discussion of the qualifications of various groups other than medicine implies that only medicine has developed the standards of entry and conduct necessary to safeguard the health of the public. We would suggest that this is not the case. Indeed, optometry has developed rigid and exacting standards for entry into professional training and for graduation into the profession. The requirements for entry into the optometry course are the same as those required to enter into any university course and have been for many, many years. The percentage of student drop-outs (20%) is similar to that in other professions. This indicates that the discipline of the subject matter is comparable.

27. The development of the precept that the welfare of the patient must always be the paramount consideration attests to the maturity and responsibility of the profession. These requirements which are embodied in the legislation and code of ethics governing optometrical practice have not been imposed from without but have been developed from within the profession with a view to safeguarding the interests of the public. Optometry is ever sensitive to the need for constant revision in their regulations to maintain the quality of vision care.

28. The suggestion that one licensing body should control entry into all the health professions is one to which the Board must take strong exception. While there may be shortcomings in the present system



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of autonomous control by each profession, this system has resulted in the development of a high standard of health care in Canada. Licensing standards can be set best by those thoroughly familiar with the requirements of their own profession. There is a need for closer co-operation between all health professions to ensure the maintenance of the highest standards, the optimum utilization of all personnel in the health care field, and the protection of the interests of the public. Consultation and co-operation would seem to be the best avenues through which advances in health care will be achieved. The Board believes that the National Health Services Planning Commission recommended by the Canadian Association of Optometrists would be a valuable instrument for obtaining such co-operation.

- (1. Board of Examiners in Optometry for Province of Ontario.
2. Canadian Association of Optometrists
3. Optometrical Association of Ontario.
4. Canadian Ophthalmological Society
5. Canadian Medical Association
6. College of Physicians and Surgeons of Ontario
7. Dr. Hannah; Transcript of hearings College of Physicians and Surgeons of Ontario, pp. 10792-10802.

29. Dr. Marshall (Dr. Marshall; Transcript of hearing Canadian Ophthalmological Society) has stated that health care on any part of the body is medical care.



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30. We must disagree that "health care" and "medical care" are synonymous. Indeed de-tistry today is providing health care, including the use of surgical techniques, without having a general medical training. We believe that optometry also has demonstrated that health care can be provided in a specialized area of practice without a general medical training.

31. The statement by the Section on Ophthalmology (Ontario Medical Association Brief; Appendix, Section on Ophthalmology) in the submission of the Ontario Medical Association would seem to further enlarge on the theme that only a physician can provide health care, viz.; "Ophthalmological opinion does not recognize any such isolated procedure as a refraction (or test for glasses); it must be part of a careful complete ophthalmic examination by an examiner well trained to discover early evidence of disease conditions and qualified to treat such conditions." The Board would agree with this statement if the last six words were deleted and believes it could then serve as a description of an optometrist.

32. However, the statement as presented is not completely in harmony with actual practice. Dr. A. D. Kelly (Dr. Kelly; Transcript of hearings Canadian Ophthalmological Society, pps. 9714-16.) General Secretary of the Canadian Medical Association has indicated that in the medically sponsored prepaid programs, the benefit of a refraction is segregated and treated differently than other medical procedures.



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Most of the plans in Canada do not provide for a refraction benefit at all; only Physician Services Incorporated, Windsor Medical Services and Manitoba Medical Services provide this benefit. The contract of Physicians Services Incorporated in face defines the refraction benefit as "testing for eyeglasses". There is, then, a recognition by the medical profession that the procedure of refraction is somewhat different from usual medical practice.

33. Because of the emphasis which has been placed on the qualifications of optometrist to recognize early evidence of disease conditions, the Board would like to describe in more detail the nature of the optometrist's training in this regard. More than one-third of an optometrical student's time is devoted to the study of "medical" subjects: elementary human physiology, general and human heredity, intermediate human anatomy, ocular anatomy, general pathology and ocular pathology.

34. The study of anatomy includes the following areas: human anatomy, neural anatomy and ocular anatomy. In addition there are studies in general and neural physiology. All of these lead to the studies in ocular pathology. These provide a student with a thorough understanding of disease processes of a general and ocular nature. Studies in ocular pathology enable the student to apply his knowledge of anatomy and physiology as an essential means of understanding the pathological process. The purpose of these courses is to enable the student to recognize



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pathology in order that a professional referral for appropriate medical care can be made.

35. In ocular pathology the external and internal diseases of the eye are studied in relation to symptoms, etiology, clinical picture, course and prognosis. Instruction in related diagnostic procedures includes ophthalmoscopy, visual field study and tonometry. These studies serve to broaden and deepen the student's understanding and recognition of pathological processes. Under the clinical guidance of a faculty instructor, ocular pathology clinics provide the student with an opportunity to examine patients with histories of ocular pathology.

36. In this connection the Board would agree wholeheartedly with the recommendation of the Canadian Dental Association that hospital facilities be made available to other health professions. The use of out-patient hospital eye clinics for training would be of great advantage to optometrists and to the public.

37. Optometry has developed its discipline from the same body of knowledge as medicine and ophthalmology. There is no part of optometrical training or practice which is contrary to accepted medical dogma. Optometry is not a cult nor has it ever been classified as such by medicine. The foundations of its discipline are based on scientific method and are as secure and firmly established as any other health profession.

38. Some physicians raise doubts as to the



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universality of these qualifications amongst optometrists. For example, Dr. Wodehouse (Dr. Wodehouse; Transcript of hearing of Canadian Medical Association, pp. 10178 and 10179.) states: "I recognize again there are a few areas in this country where there are optometrists who have not these recognized levels of training, some of them, I don't want to be slanderous, I don't want to use the term "mail order" in its literal sense, but almost on that degree. These, sir, are the people who cause us concern. Very poorly qualified level of optometrist who really causes trouble". Again in response to the suggestion that only those who qualify may practice optometry Dr. Wodehouse replies: "Specifically this is an area in which I am not familiar. I think if these gentlemen say they do so, then without further investigation I would have to accept their statement. I personally believe there are many, many optometrists who have not been so examined and who would not meet the qualifications which they describe".

39. In reference to this question which Dr. Wodehouse raised, Dean Fisher (Dean Fisher; Transcript of hearing of Board of Examiners in Optometry for the Province of Ontario, p. 9651.) during the presentation of the submission explained that after the passage of the original Optometry Act in Ontario in 1921, entry into the profession was restricted to those who received the required training. The only exceptions to this were those who received exemption under the original Act. To check the accuracy of this



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Transcript of hearing of Canadian Medical Association,
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statement the Board undertook a study of each optometrist in Ontario from the data on its register. Of the 523 optometrists registered in Ontario from the data on its register. Of the 523 optometrists registered in Ontario today, 88 were registered at the time of the original Optometry Act in 1921. At the time of the original registration applicants were given the choice of being registered with examination or by exemption without examination.

Of those 88 who were granted registration and who still remain registered today, 42 were registered by examination. Moreover, it cannot be assumed that this group failed to keep pace with the growth of knowledge in the optometrical field. The widespread availability of post-graduate knowledge through the medium of conventions, seminars, regional lectures, post-graduate courses and current literature, as well as the factor of experience gained through practice, make it safe to assume that most of these men attained a level of competence commensurate with today's requirements. Attendance at the annual educational sessions of the Optometrical Association of Ontario normally runs from 20 to 30 percent of all practising optometrists in Ontario.



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statement the Board understood a study of each optometrist in Ontario from the data on its register. Of the 583 optometrists registered in Ontario from the data on its register. Of the 515 optometrists registered in Ontario today, 58 were registered at the time of the original Optometry Act in 1911. At the time of the original registration applications were given the choice of being registered with examination or by exception without examination. Of those 58 who were granted registration and who still remain registered today, 42 were registered on examination. However, it cannot be assumed that this group failed to keep pace with the growth of knowledge in the optometrical field. The widespread availability of post-graduate knowledge through the medium of conventions, seminars, regional educational sessions of the Optometrical Association of Ontario currently runs from 10 to 50 percent of all practising optometrists in Ontario.



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TABLE I -

TABLE SHOWING AGE DISTRIBUTION OF ONTARIO OPTOMETRISTS

AUGUST, 1962

<u>AGE GROUP</u>	<u>NUMBER</u>
20 - 24	7
25 - 29	14
30 - 34	35
35 - 39	86
40 - 44	97
45 - 49	81
50 - 54	37
55 - 59	30
60 - 64	47
65 - 69	46
70 - 74	29
75 - 79	10
over 80	<u>4</u>
	523

Mean age 48.6 years

Of this number 16 are female (3%)

In addition to these there are 17 honourary registrants who are over 80 years of age. For the most part they are not practising.

40. Table I shows the age distribution of Ontario optometrists. The group over age 65 comprise the group who received exemption in 1921. No optometrist may be registered who has not received the training indicated in the curriculum. While a detailed



1951

1952

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TABLE SHOWING AGE DISTRIBUTION OF ONTARIO OPTOMETRISTS

1951 1952

Age

Age

14

15 - 20

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21 - 24

16

25 - 29

17

30 - 34

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35 - 39

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40 - 44

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45 - 49

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50 - 54

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55 - 59

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65 - 69

70 - 74

75 - 79

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115 - 119

120 - 124

125 - 129

130 - 134

Mean age 45.6 years

Of this number 10 are female (7%)

23 In addition to these there are 14 non-regular registrants
24 who are over 60 years of age. For the most part they are

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trist may be registered who has not received the train-
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study has been made in Ontario, similar statements would apply to all provinces of Canada. The suggestion that there are "many, many optometrists who have not been so examined" does not hold up under inspection.

41. Dr. Nicholls (Dr. Nicholls; Transcript of hearings Canadian Ophthalmological Society, pps. 9710-11) has presented figures indicating that in a group of 327 patients presenting themselves for refraction "45% had associated eye disease; 13% had an associated general disease affecting their eyes". The implication of this statement presumably is that since so large a percentage show pathological manifestations the problem of refraction is largely a medical problem. Appendix 'A' attached gives a review of the literature, largely medical, which indicates that the incidence of disease as manifested in the eye is less than 5 percent in the general population.. This evidence based on large and varied samples would seem to demonstrate conclusively that refractive procedure is concerned primarily with the healthy eye.

42. Another statement made before the Commission (Canadian Ophthalmological Society Brief, p.4.) asserted that "The only adequate eye care is medical eye care". This statement seems to be based on three propositions. First, only a physician can provide health care. This has been discussed previously. Second, the incidence of ocular disease is so high as to make the provision of vision care largely



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a medical problem. This has been discussed above. Third, refraction can only be carried out adequately with the use of cycloplegics (Transcript of hearings, Canadian Ophthalmological Society, p.9720) particularly for children; and, manifestations of disease can only be observed by the use of drugs.

43. Appendix 'B' contains a discussion of the use of cycloplegics in refraction. It is evident that medical opinion is not in agreement on the question of the use of cycloplegics. Medical practice does not utilize cycloplegics routinely as was indicated in the hearing before the Commission (Transcript of hearing, Canadian Ophthalmological Society p. 9726). Indeed, a strong argument could be advanced that the use of cycloplegics is an undesirable practice since the measurement of the refractive state of the eye is made with the ciliary muscle paralysed rather than in the normal state of use and so introduces artificial conditions. But in point of fact, optometrists and ophthalmologists have demonstrated that the refraction of the eye can be determined by either method by a skilled examiner with clinical results that are in very good agreement. It is natural that practitioners should stress the method in which they have been trained and are skilled in applying but it does not follow that one procedure has advantage over the other. In Great Britain, where optometrists may employ cycloplegics if they wish, the examination of choice is the non-cycloplegic examination.

44. Similarly, the statement that one cannot



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properly assess the relationship between accommodation and convergence without the use of drugs is incorrect. In fact the relationship between the two functions can only be determined when both accommodation and convergence are functioning normally and cannot be assessed when drugs are used.

45. Nor is the use of drugs to examine the internal eye essential. Indeed general medical practitioners, internists, neurologists and many other physicians use the ophthalmoscope for diagnostic purposes in routine practice and do not ordinarily employ drugs to dilate the pupils. The optometrist is similarly skilled in the use of the ophthalmoscope to determine the presence of manifestation of diseases in the eye and when any doubt exists, referral is made to a medical practitioner for diagnosis.

46. It would seem then that the problem of recognition of optometry by medicine is related more to medicine's general philosophy than any 'health care is medical care' than to any demonstrated deficiencies in optometrical procedures or training. In the light of the facts, this philosophy seems difficult to support.

47. In fact, there is evidence of medical acceptance of optometrical qualifications. Dr. Wodehouse (Dr. Wodehouse; Transcripts of hearings, Canadian Medical Association, p. 10178) for example, states: "There are undoubtedly some schools of optometry where these conditions of training and the recognition of



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something abnormal pertain, and there are undoubtedly optometrists in this city and others who recognize there is something wrong other than just refraction error and refer patients, quite ethically and properly, to an eye doctor". Also he says; "I have to recognize there are many good optometrists who can test my eyes or your eyes and who might if I had ocular disease, recognize it and send me for treatment.

48. Similarly Dr. Hannah (Report of year ended April 28th, 1961 - College of Physicians and Surgeons of Ontario: Legislation) in a report to the Ontario physicians remarks; "There is also another group who elect one particular part of the body in which to exercise their limited capacities, e.g., podiatrists and the optometrists, etc.. The medical profession in some of these cases have left a void by failing to meet the needs of the community in which they practice.. This is very evident in the growth and use of optometrists. There is little, if any, excuse for the profession's failure to meet the needs of the public in these respects. However, having failed to do so and continuing to do so, there can be little complaint against those who make an honest effort to meet the needs of the public, although it may be in a less satisfactory plane that if we as a profession had met the need and filled the void."

49. The Canadian Medical Association (Preliminary submission to the Royal Commission on Health Services; Journal of the Canadian Medical Association, Vol 85, September 30, 1961 - p. 803, par. 16.)



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referred to the host of "para-medical workers" associated in providing health services. It includes optometry among the groups required by the "team approach" in modern health care.

50. At the practitioner level, almost every optometrist numbers among his patients, several physicians, their families or patients whom physicians have referred to an optometrist for vision care. These referrals surely attest to a high degree of confidence in the qualifications of the optometrist on the part of the medical practitioner.

Conclusions

51. In the various proceedings before the Commission referred to above, statements have been made which seem to question the competency of optometrists to fulfill their function. A review of these statements indicates that there is no valid basis for such charges.

52. The problem of defending the competency of a profession is a most difficult one to undertake. How does one judge the competency of a profession.

53. We could suggest that this judgment of the competency of optometry has long since been made:

- by the public, who by and large visit optometrists for their vision care.

- by the legislatures of every province in Canada and throughout the civilized world through enactment of legislation defining the practice of optometry,



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At the practitioner level, almost every optometrist number among his patients, several physicians, their families or patients whom physicians have referred to an optometrist for vision care. These referrals testify to a high degree of confidence in the qualifications of the optometrist on the part of the medical practitioner.

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restricting it to those properly qualified, and safeguarding the interests of the public.

- by the various branches of government which utilize the services of optometrists in the provision of vision care at the municipal, provincial and federal levels.

- by the armed services, and health service organizations which utilize the services of optometrists in their professional capacities.

- by various universities in Canada and throughout the world which have established optometry faculties.

III. SUMMARY AND CONCLUSIONS

54. In conclusion, the Board would like to express its thanks to The Royal Commission on Health Services for the interest it has shown in the matters dealt with in our submissions. We hope the information, which the Board has supplied the Commission, will be of real value in making its report to the Government concerning the provision of high standards of vision care for the Canadian people.

55. We recognize that a good deal of what we have said, has emphasized the importance of the part that optometry plays in caring for the nation's health. In this respect let us say, that we have tried to avoid being so self-centered and so preoccupied with



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5 out own problems that the interests of others have not
6 been considered. We have tried to avoid taking too
7 narrow a view in our examination of the existing
8 circumstances, although we recognize the difficulty
9 in comprehending all the factors in this complex
system.

10 56. We believe that the conclusions we have
11 made and the recommendations we have suggested will
12 be found in keeping with the facts as ascertained by
13 the Commission. We also believe they are consistent
14 with the interests of all people requiring vision
services either now or in the future.

15 57. The fact that we have rebutted at some
16 length the statements and inferences made during the
17 hearings and in some of the briefs concerning the
18 licensing of optometrists, their competency and the
19 importance of their work in the field of vision care,
20 can be accounted for by our concern, that if these
21 serious charges were not answered, then some mis-
22 understanding might arise in the minds of others, as
23 to the reasons for our silence. Similarly, it was
24 felt that it was necessary to deal quite frankly with
25 what we believe to be the harm and limitations of the
26 present prepaid comprehensive medical plans as they
relate to vision services.

27 58. From what has been said we hope that we
28 have made it clear, that vision care is an important
29 part of health care and that the greater part of vision
care is provided by optometrists.

30 59. We have pointed out that there is a danger



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of serious shortages of optometrist unless we can act now to prevent them. The main problem facing the Board in assisting in the training of adequate numbers of optometrists is our inability to finance the expansion of our present training facilities.

60. These things we have tried to impress upon the Commission as being relevant to their considerations of vision care services. The fact is, however, that in spite of the ample representation that optometry has at the practice level, it is as yet poorly represented in the departments of government. This makes it more difficult for optometry to work with those in authority, and therefore, when the Board has this opportunity, it is important that it makes its position clear.

61. Finally, we have indicated that health care services and the manner in which they are rendered to the public need the guidance and offices of the governments, if all parts of this system are to function efficiently and effectively.

62. In closing, the Board would like to express to the Members of the Royal Commission on Health Services its best wishes for success in their deliberations and in making their report.



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IV

APPENDIX 'A'

The Incidence of Ocular Diseases, and General Diseases
As Manifested in the Eye

In a submission before the Royal Commission on Health Care, Nicholls (1) reported that "out of a total of 526 consecutive patient visits to an office---- 62% came ostensibly for refraction ----. Of the 62% or 327 patients, 43%, a little less than half turned out actually to only require a simple refraction. 45% had associated eye diseases, 13% had associated general disease affecting their eyes."

A review of the literature suggest that the figures for the incidence of ocular pathology in the general population vary with the sample selected, the age distribution, the method of examination and the criteria employed in establishing the diagnosis. The following review of the literature indicates the results obtained by other investigators in a variety of studies.

The Canadian Sickness Survey (2) was carried out during a twelve month period starting in the autumn of 1950. The survey was initiated by the Department of National Health and Welfare and carried out by the ten provincial health departments with funds made available to the provinces through the National Health Program. Over 10,000 Canadian households were included in this study.

Table I reports the incidence of eye diseases in the general population to be 2.88 percent as



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found in the Canadian Sickness Survey.

Table I. Incidence of eye diseases in over 10,000 Canadian households

The Canadian Sickness Survey

Conjunctivitis and ophthalmia	0.37%
Hordeoleum (styes) and other inflammatory eye diseases	1.84%
Other diseases of the eye	<u>0.67%</u>
Total.....	2.88%

Sydenstricker and Britten (3) reported on the physical impairments found in 100,924 adult white policyholders who had previously passed an insurance medical examination. The data was collected by 9,000 practising physicians of "at least average ability" at head office locations and elsewhere, but chiefly in New York, Chicago and Boston.

Table II. Table showing incidence of ocular pathology in 100,924 adult white policyholders

	<u>Head Office</u>	<u>In Field</u>	<u>Average</u>
Diseases of external eye or eyelid	1.20%	0.66%	0.93%
Eye ground changes	0.26%	0.15%	0.20%
Cataracts	0.22%	0.13%	0.18%
Total.....	1.68%	0.94%	1.31%

Table II gives the incidence of eye



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disease as found at the head office, in the field and the average of the two sets of data. The incidence was greatest in the examinations carried out at the head office location which were possibly more thorough. The average incidence was 1.31% while the maximum incidence was 1.68%

Table III. Table giving incidence of eye disease in relation to age (population 100,924)

	Under 30 years of age	30-44 years	45-54 years	Over 55 year of age
Diseases of external				
eye and eyelid	0.77%	0.71%	0.72%	0.76%
Eye ground changes	0.10%	0.17%	0.19%	0.29%
Cataracts	0.06%	0.11%	0.20%	0.79%
Totals.....	0.93%	0.99%	1.11%	1.84%

Table III indicates their data for the incidence of eye diseases related to age. The authors conclude that eye ground changes and cataract show marked increases with age and that diseases of the external eye and eyelid exhibit no definite trend. They also report that defective vision (visual acuity) shows a marked increase with age. It will be noted that the highest total percentage of ocular disease is 1.84% in the age group over 55 years of age.

In Great Britain a study (4) was made by 120 medical practitioners of some 280,000 clinical records for the twelve months, May 1955 to April 1956.

Table IV gives the results of this



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study with regard to the incidence of eye diseases. Under the National Health Service both optometrist and ophthalmologists must inform the general practitioner when ocular pathology is observed. As a result the figures can be considered to be of a high order of reliability. It is seen that the incidence of eye pathology disclosed was 20.99 per thousand (2.1 percent) for males and 36.29 per thousand (3.63 percent) for femals. For the group taken as a whole based on a population of 382,829 the rate is 33.3 per thousand (3.3 percent). This rate of 3.3 percent is in close agreement with that found by the Canadian Sickness Survey.



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and 36.49 per thousand (3.65 percent) for females. For
the group taken as a whole based on a population of
582,819 the rate is 28.5 per thousand (2.85 percent). This
rate of 2.8 percent is in close agreement with that found
by the Canadian Sickness Survey.

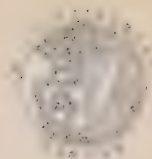


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Table IV. Numbers and rates per 1000 population of
patients consulting by sex and disease (all ages)

DISEASE OR CONDITION	MALES		FEMALES	
	population at risk	Rate per thousand	population at risk	Rate per thousand
	180,060		202,769	
	Patients Consulting		Patients Consulting	
	Number	Rate per thousand	Number	Rate per thousand
<u>Inflammatory Diseases of the Eye</u>				
Conjunctivitis and ophthalmia	2,509	13.9	2,869	14.1
Blepharitis	566	3.1	851	4.2
Hordeoleum (stye)	873	4.8	1,521	7.5
Iritis	52	0.3	90	0.4
Keratitis	32	0.2	32	0.2
Choroiditis	10	0.1	13	0.1
Other inflammation of uveal tract	34	0.2	47	0.2
Inflammation of optic nerve and retina	10	0.1	19	0.1
Inflammation of lach- rymal glands & ducts	101	0.6	208	1.0
Other inflammatory diseases of eye	39	0.2	48	0.2
<u>Other Diseases and Conditions of the Eye</u>				
Corneal ulcer	166	0.9	152	0.7
Corneal opacity	24	0.1	56	0.3
Pterygium	---	---	5	0.0
Cataract	191	1.1	400	2.0
Detachment of retina	26	0.1	19	0.1
Glaucoma	86	0.5	163	0.8
Other diseases of eye	675	3.7	855	4.2
TOTAL	5,394	20.99	7,348	36.29



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Table 17.

Table 17. Numbers and rates per 1000 population of

patients consulting by sex and disease (all ages)

Disease	Males		Females		Total
	Number	Rate	Number	Rate	
Other diseases of eye	675	20.00	825	20.00	1500
Glaucoma	165	7.5	165	7.5	330
Detachment of retina	19		19		38
Cataract	175		175		350
Corneal ulcer	175		175		350
Conditions of the eye	175		175		350
Other diseases and	175		175		350
diseases of eye	175		175		350
Typical glands & ducts	101		101		202
Inflammation of lacrimal	101		101		202
nerve and retina	101		101		202
Inflammation of optic	101		101		202
nerve tract	101		101		202
Other inflammation of	101		101		202
Chorioiditis	101		101		202
Keratitis	101		101		202
Iritis	101		101		202
Hordeolum (stye)	101		101		202
Alpharthritis	101		101		202
Conjunctivitis and	101		101		202
of the eye	101		101		202
Consulting	101		101		202
Population	101		101		202
at risk	101		101		202
Population	101		101		202
Rate per	101		101		202
Number thousand	101		101		202



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Blum, Peters and Bettman (5) report on the incidence of organic problems uncovered in the Orinda study. In this study, clinical evaluation was made of a team of two optometrists and two ophthalmologist on 941 children in grades 1 - 6 in each of the years 1954, 1955 and 1956. The incidence of eye disease reported was 3.3% (1954), 2.1% (1955) and 2.1% (1956). They report "organic problems were of two principal types. The relatively minor medical problems such as blepharitis or styes, which constituted the greatest number of organic conditions, cleared in a short time with proper medication or ran their course and cleared spontaneously. The congenital defects were placed under observation but some were uncorrected. There were few of these in the population studies."

Levine, Smith and Kitching (6) made a study of vision testing procedures in 3273 kindergarten and grade one children. This study was made possible by a federal grant for Public Health Research and approved by the Ontario Provincial Department of Health. A group of ophthalmologists and optometrists carried out the examination procedure; 31 childre (0.86%) were referred because of suspected abnormalities. They report "Apart from one case of retinitis, three cataracts, and three nystagmus, the majority of the other conditions were not too serious, including blepharitis, foreign body, cupping, ptosis, etc." The examination for eye diseases has since been dropped from the testing procedure since the low incidence did not warrant the time spent uncovering the defect.



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Figures relating to the incidence of glaucoma in the general population have varied from 0.02% to 15.7%. Recent mass screening surveys have given some indications. Brow and Kerber (7) found an incidence of 2.24% of borderline to definite glaucoma. The Cleveland glaucoma survey (8) reported an incidence of about 2% also. Carvill (9) reported an incidence of 1.35% found in 30,000 patients admitted to the eye out-patient department of Massachusettes Eye and Ear Infirmary. Armstrong, Darly, Dobson and Girard (10) in 280 patients from the general medical out-patient department found an incidence of 1.4%. There seems to be general agreement that the incidence of chronic simple glaucoma in the general population is in the range of 1.0% to 2.0%, (11).

Age has a considerable bearing on the percentage of glaucoma found. Thus Horsley, Lewis and Packer (12) found that 4% of 1,120 patients over 40 years of age in an out-patient clinic had unrecognized glaucoma. Their data showed a higher incidence apparently due to the presence of an older age group.

Data relating to the incidence of cataract substantiates the findings of Sydenstricker and Britten (3) that the incidence of cataracts increases with age. Fischer's data (13) shows the expectancy of cataract is almost 100% if the individual lives long enough. Cataracts vary considerably in the degree to which they affect visual function. From this view point, relatively few patients with cataract require surgical intervention. This is indicated by the data of Kornswieg, Feldstein and Schneider (14). In a group of over 1,000 residents of an



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old age home with ages ranging from the sixties to the nineties, they found that in the group over 80 years, 76% had cataract. Table V indicates the extent of surgical treatment required.

Table V. Table showing incidence of cataract and number operated in an old age home, population over 1,000.

	Incipient Cataract		Immature Cataract		Operable Cataract		Operated	
	No.	%	No.	%	No.	%	No.	%
under 80	294	41.2	332	46.5	49	6.9	38	5.4
over 80	120	20.4	338	57.6	72	12.2	57	9.8
Totals	414		670		121		95	

Depending on the criteria employed in categorizing cataract one might then report a wide variation of incidence for data in the same sample. The choice of criteria is an important determinant in comparing two sets of data. If the incidence of cataract is defined as the incidence of operable cataract, then the incidence is relatively low. If the definition is relaxed to include any evidence of cataract then the incidence would be relatively high.

The Association of Optical Practitioners (15) examined the records of 56,122 employees in Royal Ordnance Factories for whom vision care was provided as part of a program to maintain health and produce efficiency during World War II. Table VI presents the percentage of referrals found necessary because of ocular signs of disease.



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Table VI. Table showing percentages referred for ocular signs of disease in Royal Ordnance Factories during World War II. 56,122 Employees.

	No Referral	Referred to Ophthalmologist	Referred to General Practitioner	Referred Elsewhere	Total
Females	95.8%	0.4%	3.6%	0.2%	100.0%
Males	94.4%	1.1%	4.3%	0.2%	100.0%
Combined	95.3%	0.7%	3.8%	0.2%	100.0%

From this table it is seen that the total incidence of referred manifestations of disease was 4.7% of this sample.

Table VII. Referrals due to external anomalies of the eye in Royal Ordnance Factories during World War II. 56,122 Employees.

	No Treatment required	Treatment required
Female	98.3%	1.7%
Male	96.4%	3.6%
Total	97.7%	2.3%

Table VII indicates the percentage in the same sample requiring treatment on the basis of external examination of the eye only. On this basis 2.3 percent would require treatment.



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Table VIII. Table showing results of Ophthalmoscopic Examination of 56,122 Employees

	Normal	Congenital or Stationary Defects	Treatment Required
Female	96.0%	3.2%	0.8%
Male	92.5%	6.0%	1.5%
Total	95.0%	4.0%	1.0%

Table VIII illustrates the percentage of referrals based on ophthalmoscopic examination of the eye. It indicates that there were 5% of the employees exhibiting ocular abnormalities but only 1% required referral for attention. The overall incidence of eye diseases reported in this survey (4.7% - Table VI) does not include defects found to be present but not requiring treatment. If a different criterion was applied so as to enumerate all the abnormalities whether requiring treatment or not, the overall incidence figure would be about twice as high.

The study involved 38,193 females and 17,929 males; 81.73% of the women were between the ages of 20 and 50 years; 79.21% of the men were between the ages of 30 and 60 years. The higher referral rate for men reported in Table VI would be a reflection of age differences in the male and female samples rather than sex differences. The incidence of ocular diseases reported in this study is likely close to that of the general population. While there are not many of the upper age group included, there are also none of the very young. The absence of the former group would tend to lower the



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incidence, while that of the latter would tend to increase the incidence figure found.

Baker (16) carried out two studies in 1957 and 1960. In 1957, 138 optometrists examined the records of 100 successive patients each. In 1960, 278 optometrists examined the records of 50 consecutive patients each. Both samples contained the results of almost 14,000 patients. In the 1957 study, 4.4% of the total number were referred to medical practitioners. In the 1960 study, 6.1% were referred for attention. Again the effect of age is quite apparent. In the 1957 sample, the median age fell within the 21-40 years interval while in the 1960 survey, the median age fell within the 41-50 years interval. Thus as might be expected, the sample with the higher proportion of older people showed the higher incidence of eye disease. The population studied here is a clinical group of patients seeking attention, whereas in the Royal Ordnance Study, the whole working population is included. Nevertheless, the close approximation of values in the two studies is striking.

Kintner (17) in a similar study reported a referral rate of 2.19%.

Summary and Conclusions

A review of the literature relating to the incidence of eye disease discloses wide variations in the samples as to age and number as well as differences in the criteria used to establish diagnosis and the methods of examination.



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Table IX. Summary of studies of (a) the incidence of ocular pathology in the general population and (b) the rates of referral by optometrists.

(a) Incidence of Pathology

Sydenstricker and Britten	Canadian Survey	British National Health Services	Nicholls
pop. 100,924	10,000 households	pop. 382,829	pop. 327
1.31%	2.88%	3.30%	45.00%

(b) Referrals by Optometrist

Kintner	Baker	Baker	Association of
U.S.A.	Canada	Canada	Optical Prac-
N=235,213	pop. 14,000	pop. 14,000	titioners Great
	(1957)	(1960)	Britain
			pop. 56,122
2.2%	4.4%	6.1%	3.8%

Table IX reviews the incidence of eye pathology reported in various studies. With the exception of the data of Nicholls they all indicate an incidence of ocular pathology well below 5% of the general population. The referral rates reported in three optometrical studies show good agreement with these results. The Canadian figures for referrals include not only referrals for eye diseases but also systemic diseases as manifested in the eyes. As would be expected, the referral rate is therefore higher than the incidence figures found in the three major studies. This would seem to substantiate the conclusion that optometrists are in fact uncovering evidences of disease in the proportion that would be



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expected from the incidence in the general population.
The competency of optometrists to perform their essential
task of differentiating the unhealthy eye from the
healthy one is well supported by the evidence.

The wide difference in the data of
Nicholls (1) would seem to be due to some artifact in
the size and composition of the sample or in the criteria
applied.

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V

APPENDIX 'B'

The Use of Drugs in Refraction and Examination

CYCLOPLEGICS IN REFRACTION

DEFINITION

A cycloplegic is an agent such as a drug which induces a paralysis of the ciliary muscle of the eye, thereby preventing the act of accommodation (the adjustment of the focus of the eye for various distances).

A cycloplegic usually induces dilation or enlargement of the pupil of the eye (spoken of as mydriasis) as a side effect. On the other hand, a mydriatic may dilate the pupil but may not produce any appreciable effect on the focussing ability.

Many cycloplegics are available but the common ones include atropine, homatropine, hyoscine and lachesine. All of these inhibit the focussing ability and produce dilation of the pupil. They are administered in the form of drops, ointment or wafer as the physician may decide. Dilation of the pupil without paralysis of the focussing mechanism may be produced by cocaine, adrenaline and ephedrine.

USE OF CYCLOPLEGICS

There is considerable divergence of opinion regarding the need for cycloplegics in refraction. These divergent views have existed for many years. In 1908, Lucie-Howe (1) states "The arguments for and



APPENDIX C

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USE OF CYCLOPLEGICS

There is considerable divergence of opinion regarding the need for cycloplegics in refraction. These divergent views have existed for many years. In 1908, Lucie-Howe (1) states "The arguments for and



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against cycloplegics can be summed up by saying that while it is possible to obtain an accurate satisfactory correction of the ametropia without a cycloplegic, it is certainly more difficult to do so than with its assistance, and taking into account the inconvenience to the patient, it is simply a matter of judgment in each case whether its use should be advised or not." Harrison T. Butler (2) a prominent English ophthalmologist states in a paper presented to the Ophthalmological Society of the United Kingdom in 1922, ".... that refraction without a cycloplegic is as accurate as that with one if only correct methods are employed, and if sufficient experience and skill are at the hands of the refractionist." Sir Edward S. Duke-Elder, who is considered the leading ophthalmological authority in the world today comments regarding the disadvantages of cycloplegics as follows (3). "They eye with its accommodation paralysed is a pathological eye, and cannot be legitimately compared with the normal organ. The dilation of the pupil alters considerably the optical properties of its refractive apparatus, and intensifies the physical errors due to aberration through the peripheral parts of the refractive media. Further, the periphery of the pupillary aperture frequently has a refraction quite different from the central part, which is alone employed in the normal circumstances of life."

Duke-Elder also writes in his "Textbook of Ophthalmology" (4) as follows:

"The question as to whether accommodation for near vision should be paralysed before any estimation



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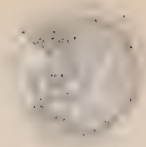


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of the refraction, has excited much controversy. Some writers consider the universal use of cycloplegics necessary at any rate until the age of 50 when the accommodative power becomes negligible; others insist that the practice is unnecessary except in the case of young children, while others again suggest that it is as a general rule inadvisable. There is no doubt that, properly used, a cycloplegic offers the most certain means of eliminating accommodative effects and of assessing the total refractive error; and it is also true that for the beginner the accompanying mydriasis makes the clinical estimation easier. The mydriasis is also of value in making a full ophthalmoscopic examination possible, and may be necessary when the pupils are small to obtain a macular or paramacular refraction.

At the same time the use of these drugs is attended with disadvantages, optical, medical and economic. The optical disadvantages are three. In the first place, under cycloplegia the lens is in a strained condition and is deformed so that after it has assumed its normal shape, minute errors cannot reasonably be transposed to the dioptric system in the ordinary conditions of use; we have seen that there is often a considerable difference between the astigmatic error in an accommodated and non-accommodated eye, and it therefore follows that the abnormal refraction under cycloplegia must be modified by a further determination of the refraction in normal conditions. In the second place the periphery of the pupillary aperture frequently has a refraction different from the central part, which is alone



of the refraction, has excited much controversy. Some writers consider the universal use of cycloplegics necessary at any rate until the age of 50 when the accommodative power becomes negligible; others insist that the practice is unnecessary except in the case of young children, while others again suggest that it is as a general rule inadvisable. There is no doubt that, properly used, a cycloplegic offers the most certain means of eliminating accommodative errors and of assessing the total refractive error; and it is also true that for the beginner the accompanying mydriasis makes the clinical estimation easier. The mydriasis is also of value in making a full ophthalmoscopic examination possible, and may be necessary when the pupils are small to obtain a macular or papillary refraction.

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employed in the normal circumstances of life, and in the former errors of aberration are an almost constant occurrence. The expert will be able to neglect the peripheral disturbances and confine his attention to the central area; or alternatively an artificial pupil can be used. In the third place cycloplegia affords no adequate recognition of accommodative anomalies or unusual accommodative habits, allowance for which is frequently advisable in the prescription of spectacles: again, a post-cycloplegic test is necessary. From the medical point of view there is an element of danger in patients pre-disposed to glaucoma lest an acute attack be precipitated. It is true that in the normal eye such a danger is non-existent, and that, where danger does exist, it is usually eliminated by a subsequent miotic. Before cycloplegic drugs are used, therefore, the possibility of such a complication should always be excluded, and when doubt is felt only transient agents should be employed and the patient should be kept under observation until the pupil is fully contracted by the subsequent instillation of eserine. The rare occurrence of belladonna poisoning from the ocular instillation of atrophine is to be remembered. From the economic point of view the process of refraction under cycloplegia requires three examinations - a preliminary one, an examination under cycloplegia and a post-cycloplegic test at a later date. This may be an inconvenience to the surgeon and frequently is to the patient, particularly if the effect of cycloplegia is prolonged, although it can be mitigated by the subsequent use of a miotic, which should be a

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routine in all adult cases. Rapidly acting drugs such as paredrine or euphthalmine are essentially mydriatics and their cycloplegic effect is small; their use as cycloplegics is therefore illusory."

After commenting on some of the indications and contra-indications on the use of cycloplegics, Duke-Elder adds (5):

"On the whole where the optical conditions are good and the room large so that accommodation can be relaxed, where the surgeon is an expert and is prepared to spend a little time on the estimation, and where the patient is reasonably intelligent and co-operative and is an adult who is not suffering from accommodative disturbances which cannot be otherwise assessed, there is no doubt that the ideal refraction is the one estimated in the absence of a cycloplegic. Provided, however, cycloplegics are employed with discrimination and provided correcting spectacles are prescribed thereafter not by rule of thumb but only after an adequate post-cycloplegic test, little can be said against their use."

Bannon (6) reported on a study conducted at the Dartmouth Eye Institute in co-operation with four ophthalmologists and four optometrists. Clinical cases were selected from the routine cases refracted at the clinic. The regular method of examination was a non-cycloplegic refraction but where the examiner felt that a cycloplegic refraction might throw additional light on the patient's usual problem for the condition of his eyes, a cycloplegic was used.

Selecting data on 1,000 eyes where both



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cycloplegic and non-cycloplegic refractions were conducted,
Bannon concluded that:

"1. In 74.4 percent of the cases the spherical findings obtained by the two methods agrees with clinical limits of ± 0.50 Dioptres.

2. In 84.5 percent of the cases the astigmatism found by the two methods agrees with clinical limits of ± 0.25 Dioptres.

3. In 81.8 percent of the cases the axis of the astigmatism found by the two methods agrees with clinical limits of $\pm 5.0^\circ$."

Bannon goes on to state:

"In the opinion of the writer, the foregoing conclusions offer striking evidence that both the cycloplegic and the fogging techniques give the same findings in the majority of cases In those cases where the ametropia findings without and with cycloplegia did not agree, it cannot be concluded that the results from one method are more accurate than from the other."

Mitchell, an English optometrist who was for many years director of education at the London Refraction Hospital, states (7) "Cycloplegics undoubtedly make the actual examination of children much easier, but they do not simplify matters to the extent of our being able to write as the ideal prescription our retinoscopic or subjective estimation of the refractive error. If, for instance, + 6D. is found in the cycloplegic test, this power is not necessarily prescribed: the experienced refractionist does not always prescribe a full correction



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even though he may have been at pains to disclose the total error. Several factors should be taken into consideration when writing the prescription for lenses, as will be pointed out presently, and - this is the important point at the moment - many of these factors depend upon conditions which cannot be investigated when the eyes are under a cycloplegic."

From the foregoing it can be seen that there is little agreement among either ophthalmologists or optometrists regarding the necessity of a cycloplegic. A satisfactory refraction can be obtained either with or without a cycloplegic in the vast majority of cases. The method of choice will depend on the techniques used and the training and skill of the practitioner.

Pertaining to the methods used for determining the relationship between the accommodation and the convergence of the eyes, Mitchell (8) points out in his text the following:

"More and more we are coming to appreciate the fundamental importance of the accommodation-convergence relationship in the easy and correct functioning of the eyes as a binocular organ of vision. Information concerning this relationship can be obtained by a comparison of the distance and near imbalances; by measuring the near imbalance and comparing it with that found in the distance test we determine how much convergence comes into play when accommodation is exerted, and various conditions in which there is excessive ciliary effort may be revealed in this way. It must be obvious that any reading obtained in a near imbalance test when



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accommodation is abolished, as under atropine, has not the slightest significance from this point of view - the imbalance normally present at the reading distance cannot be determined under cycloplegia. How essential it is, then, to obtain as much information as possible on this point before atropine is instilled."

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 - (2) Butler, Harrison T. - Refraction with cycloplegics, Transactions of the Ophthalmological Society of the United Kingdom, Vol. XLII, Session 1922, London, pp. 127-147.
 - (3) Duke-Elder, Stewart - The Practice of Refraction, The Blakiston Company, Philadelphia, 1945, 4th Edition, pp. 147-148.
 - (4) Duke-Elder, Sir W. S. - Testbook of Ophthalmology, Vol. IV, C. V. Mosby Co., St. Louis, 1949, pp. 4372-3.
 - (5) Ibid., pp. 4374.
 - (6) Bannon, R. E. - The Use of Cycloplegics in Refraction. American Journal of Optometry, Vol. 24, November, 1947, pp. 513-568.
 - (7) Mitchell, D. W. A. - The Use of Drugs in Refraction, The Hatton Press, London, 1947, pp. 33.
 - (8) Ibid., pp. 34.



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MR. BAKER: - If I may make just a few opening remarks, Mr. Chairman --

THE CHAIRMAN: Mr. Baker, before you begin, I notice we also have a submission from the Optometrical Association of Ontario. Now, do these two necessarily dovetail?

MR. BAKER: The answer is yes and no. It is not a satisfactory one.

THE CHAIRMAN: But you prefer to do it separately?

MR. BAKER: I think so.

Mr. Chairman, we hope that we have made it clear in our previous presentation and in this supplementary brief that vision care is an important part of health care and that the greater part of vision care is provided by optometrists.

We point out that there is a danger of a serious shortage of optometrists unless we can act now to prevent that. As a matter of fact, we followed with great interest the previous delegation on that point. The main problem facing the Board in obtaining adequate numbers of optometrists is our difficulty in financing our present training facilities. The solution suggested is that an optometrical education be given in the university. In bringing this about the Board has not been successful to date.

We have rebutted some lengthy statements and inferences made during the hearings in some of the briefs relating to optometrists, and our concern is that if these serious charges were not answered, then some



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misunderstanding may arise in the minds of others as to the reason for our silence. It was felt necessary to talk quite frankly about what we believe to be the limitations of the present prepaid comprehensive medical plans as they relate to vision service. We feel that the conclusions we have made and the recommendations we have suggested in our initial submission are in keeping with the facts as ascertained by the Commission. We also said that they are consistent with the interests of all people requiring vision services either now or in the future.

Mr. Chairman, we will be very pleased to try to answer all the questions that you may wish to ask in regard to our submission.

THE CHAIRMAN: Thank you, Mr. Baker. Do any of your associates wish to add anything at this time?

I think we might have some discussion on this basis. You had a lot to say about the deficiencies of the present plans, et cetera, et cetera. Now, I do not know that we are necessarily taking any firm opinion about what may happen in the future, but it is not a hard thing to do to say that things today are not as good as they should be. But what we are concerned with is the future. Would you just in a capsule for the moment say just what the Board of Examiners recommend for the future apart from the proposition of university affiliation, which we understand quite well. That is not immediately available, as you have said. Even if it did become available, it would take a number of years to



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become effective as a force in the community. Now, in the meantime, what do you want, what do you think should be done?

MR. BAKER: Well, I think perhaps the question can be answered in a number of ways. The first that appeals to me is that we must look at the facts as they exist today. The fact of the matter is that it would appear to us that people, for one reason or another, want comprehensive coverage. The method of providing this coverage to a large extent ---

THE CHAIRMAN: By "coverage" you mean what?

MR. BAKER: Health care.

THE CHAIRMAN: Payment thereof?

MR. BAKER: Yes.

THE CHAIRMAN: Prepayment?

MR. BAKER: Yes, prepayment. Perhaps why we have made it initial is that in the development of this situation and particularly in the field in which we are interested, and what the public requires, there are factors in operation which, if continued to progress in this direction, could only create a serious problem for us at the moment as to where one fits, because, as I recall, in an earlier cross-questioning here, Mr. Chairman, I believe it was you who raised the question and said if somebody pays a premium why would they not want to utilize it seeing that they paid for it. In effect, to a large extent, and it varies in different parts of the country at the moment, this is what is happening in our field where people are paying ---



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THE CHAIRMAN: Payment of losses?

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Baker

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THE CHAIRMAN: Paying a premium for health services?

MR. BAKER: Yes, for refraction, where, if this continued or was allowed to continue or if there is no compromise in this situation -- and it has a depressing effect upon our field, both in terms of our immediate practice as well as to attract young men and women into this field to meet the need -- then five or ten years from now the number of practitioners required to meet the needs as they will become obvious will not be available.

THE CHAIRMAN: Your complaint is that the coverage, the limitation of coverage in the prepaid contracts that you mention, is limited to refractions by physicians only?

MR. BAKER: Yes, that is correct.

THE CHAIRMAN: This is your main complaint in this context?

MR. BAKER: This is a problem, not only for us but for the people who buy this benefit. I don't think we can really ever divorce the two things; I think both interests have to be present.

As far as this is concerned, and I think we have tried to state this clearly, if comprehensive health insurance is going to supply to the people in Canada vision services, the only way that it can subsequently be done, both in terms of competency and numbers available, distribution and all the rest, is a matter of having both groups now involved in the situation involved in that particular type of program.



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THE CHAIRMAN: Having a premium for

MR. BAKER: Yes, for restriction, where,

if this continued or was allowed to continue or if there is no compromise in this situation -- and it has a depressing effect upon our field, both in terms of our immediate practice as well as to attract young men and women into this field to meet the need -- then five or ten years from now the number of practitioners required to meet the needs as they will become obsolescent will not be available.

THE CHAIRMAN: Your complaint is that the coverage, the limitation of coverage in the present contracts that you mention, is limited to restrictions by physicians only?

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THE CHAIRMAN: You heard the answer given by the medical people yesterday that the limitation in their contract was limited as it was because it was a physicians' plan and there it would only cover physicians' services. Can you suggest how you would extend that refraction clause to an optometrist, still on the basis of a physicians' scheme such as P.S.I., M.S.I.?

MR. BAKER: To a limited extent it does occur now in certain prepaid health programs that are underwritten by insurance companies.

THE CHAIRMAN: Yes, but I am talking about these non-profit plans which cover the greater number of prepaid people today.

MR. BAKER: I don't think there is any problem other than perhaps the administrative one involved, because the benefit is already in existence. The fact of the matter is that when one looks at it sort of objectively you could ask the question: What difference does it make whether an optometrist is licensed by law to perform the service or an ophthalmologist does it?

THE CHAIRMAN: Would your Board have any objection if, say, the P.S.I. contract, and they are pretty well the same across the country, was amended to cover refraction service by a physician or licensed optometrist? They would still administer the plan and the bill would be paid from there. Have you any objection if it could be worked out?

MR. BAKER: I like the last few words,



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"if it could be worked out." If that is so, we have no objection to it. I think it has been stressed, and perhaps over-stressed, that our group is willing to co-operate and render this service. I think the answer is yes, the Board would have no particular reservations about this, providing that perhaps certain controls were involved here. The situation is one that if it was just a matter of offering to the public a choice of licensed practitioner, I see no objection in this regard.

MR. LANGER: I think with regard to part of your earlier question, in Ontario I believe the charter of P.S.I. provides that they can purchase such services to provide such benefits as they may wish to offer, and I believe there has been some discussion of providing nursing service in a pilot program, that P.S.I. would not be restricted to physicians in the benefits they provide. We feel this is the very least that must be done to provide vision care for the people of Canada, that there shall be available the services of the practitioners to provide it and it shall be readily available and under conditions in which we continue to maintain control over the professional practice of our own people.

THE CHAIRMAN: We are only speaking now of payment. Your view, then, is if, in the judgment of government, it should be eventually decided that one of these voluntary plans, one or more of them, should be the vehicle for providing the coverage, then it must also include coverage for optometry?

"it could be worked out." I think so, we have no objection to it. I think it has been stressed, and perhaps over-stressed, that our group is willing to co-operate and render this service. I think the answer is yes, the Board would have no particular reservation about this, providing that perhaps certain controls were involved here. The situation is one that it is just a matter of offering to the public a choice of licensed practitioners, I see no objection in this

part of your earlier question, in Ontario I believe the charter of F.S.I. provides that they can purchase such services to provide such benefits as they may wish to offer, and I believe there has been some discussion of

F.S.I. would not be restricted to members in the benefits they provide. We feel this is the way least that must be done to provide vision care for the people of Canada, that there shall be available the services of the practitioners to provide it and it shall be readily available and under conditions in which we continue to maintain control over the professional practice of our own people.

THE CHAIRMAN: We are only speaking now of payment. Your view, then, is it, in the judgment of Government, it should be eventually decided that one of these voluntary plans, one or more of them, should be the vehicle for providing the coverage, then it must also include coverage for optometry?



Baker 13114

MR. LANGER: This, of course, does not provide any coverage for the full service, this provides only for the diagnostic service for refraction.

THE CHAIRMAN: You want to go further into the actual glasses, the cost of the glasses themselves?

MR. BAKER: I think that it is necessary to discuss this. The fact of the matter is that diagnosis without treatment isn't a satisfactory thing necessarily. But I think one has to be realistic about this in this sense, that we have, as was indicated earlier, to give a priority to these things. At the moment we are not prepared to say whether it is the whole business or part of it, but it certainly should be carefully examined.

THE CHAIRMAN: You talked of the system that has been in operation in England since 1948.

MR. BAKER: Yes.

THE CHAIRMAN: What has been the corresponding situation there?

MR. BAKER: Well, perhaps the Dean here can give some detail on that. The last statistical report that we have is that approximately the utilization rate in Great Britain ---

THE CHAIRMAN: I am concerned about the program, what it consists of.

MR. BAKER: It consists of refraction benefits and the supply of treatment, spectacles. I believe now there is a small deterrent fee involved in that aspect of it. The utilization rate was about 13%

13114

Page 1

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Baker

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THE CHAIRMAN: Yes, and this was part of the original program, without the deterrent fee, there was also provision for optical care.

MR. BAKER: Actually there is a body which operates as an administrator, that is from the local body. There is decentralization of boards. The situation in the United Kingdom with regard to the official relationship between ophthalmology and optometry is quite different from what it is here, and in turn it is quite different from what it is in the United States; we are sort of half-way between. By our standards, there are comparatively few problems in the United Kingdom with regard to this relationship.

COMMISSIONER BALTZAN: Did I understand you rightly, Mr. Baker? Did you say that in England optometric service by optometrists is recognized under the N.H.S.?

MR. BAKER: Oh, yes.

COMMISSIONER BALTZAN: And it can also be given by ophthalmologists and physicians who are competent in that field?

MR. BAKER: Yes.

COMMISSIONER BALTZAN: And the supervisory body is composed of ---

MR. BAKER: All groups in the eye care field. There are also laymen on that board.

MR. FISHER: I believe that both of them



per annum, of which optometrists supply in excess of 50% of those services in the United Kingdom at the present time. This is the last data we have from the --

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MR. BAKER: Actually there is a body which operates as an administrator, that is from the local body. There is decentralization of boards. The situation in the United Kingdom with regard to the official relationship between ophthalmology and optometry is quite different from what it is here, and in turn it is quite different from what it is in the United States; we are sort of half-way between. By our standards, there are comparatively few problems in the United Kingdom with regard to this relationship.

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MR. FISHER: I believe that both of them



Baker

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have what they call Whitely Councils which pass on accounts, and they also act as a disciplinary body.

COMMISSIONER BALTZAN: Which is the licensing body?

MR. FISHER: They have a similar licensing arrangement; it is slightly different. They are controlled by their own group in the licensing factor. The British Optical Association does the actual licensing.

COMMISSIONER BALTZAN: Not Optometrical Association?

MR. FISHER: Well, it is the same group. Just as in England they speak of lifts and we speak of elevators, so it is here.

COMMISSIONER BALTZAN: It is the same vision.

MR. FISHER: Yes.

COMMISSIONER GIRARD: You say in your brief that 65% of refractions are now done by optometrists and the rest by ophthalmologists. Is the percentage of refractions done by optometrists going up or going down? What is the trend in relation to the refractions being done by ophthalmologists?

MR. BAKER: I can't answer the question very well because these figures are difficult to come by. Our impression is that up until now perhaps the ratio has remained fairly constant. We are not too sure that the ratio will continue this way. If medical health schemes are permitted, if that is the right word, the expansion in the manner in which they are doing, there is no doubt, and I think we tried to state it fairly



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4 in our brief, that these have been a very disturbing
5 element to us. We have always felt, and I think it has
6 been borne out by experience in hospitals in Canada,
7 that where the situation is one where there are no
8 outside groups and where free enterprise was involved,
9 optometry, in finding its niche, is not concerned at
10 all, because it has been able to do this and has
11 progressed, sometimes in a very undesirable environment,
12 because the need was there and we have met the need.
13 But when you enter into the situation we have indicated
14 in our brief with these parties which are exerting these
15 controls, then relationship with the public generally
16 must be changed.

17 One thing that makes the problem
18 perhaps even more acute, and it is one in which we have
19 heard no explanation of it at all, is that if we assumed
20 that the prepaid medical programs now in existence were
21 to cover everyone, as they perhaps in time envisage,
22 who would be doing this work? Because certainly in
23 terms of the number of available or even expected, there
24 are not even enough.

25 THE CHAIRMAN: 4% in Canada? This is the
26 figure the Chairman of the Canadian Ophtalmological Society
27 used and we used him verbatim when he said there was the
28 equivalent of 470 ophthalmologists that work as we
29 have indicated in our brief in a situation in
30 which, allied with them, or along with them you have got
another 500 workers in the area. In terms of manpower
perhaps one could see that 1,411 optometrists are doing
approximately 65% of refractive care in Canada and that



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perhaps roughly 900 people, or 1,000 people were doing 35% and the difference, of course, is in the field of medicine.

THE CHAIRMAN: Your optometrists do optometry only?

MR. BAKER: That is right.

THE CHAIRMAN: The ophthalmologist may be an eye, ear, nose and throat man?

MR. BAKER: That is right.

COMMISSIONER GIRARD: In trying to improve your educational facilities, is this in view of the increase that could come through the prepaid plan, health care plan or just for the 65% that you are educating now? Can you take care of that under the facilities you have?

MR. BAKER: I think I can answer it this way: That in our initial submission we came to the agreement, in our own minds, that the ratio, leaving out isolated areas in Canada, it is approximately one to twelve thousand. That may not be the optimum ratio, but it seemed to be a practical one in fact, because most people can obtain care under the circumstances.

The training facilities in Canada today will not keep pace with the attrition factor, and with the increase, or expected increase in the Canadian population. In our own institution, for example, our entrance class this year was 30, which is our limit. We turned down about half as many again because we just have no slots for them. We have no provision for being able to teach these people.



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THE CHAIRMAN: As an optometrist the individual optometrist is able to render a service to a greater number of people, perhaps, than some of the other professional people?

MR. BAKER: I would say this is true.

THE CHAIRMAN: And the practice lends itself to the itinerant optometrist as well does it not?

MR. BAKER: Only in some areas.

THE CHAIRMAN: In isolated areas?

MR. BAKER: Yes, where there are perhaps two or three thousand people, or five hundred people in one center. Certainly five hundred people or one thousand people would not make it economical for an optometrist unless he somehow increased the population which he has to serve.

THE CHAIRMAN: What is the degree of this going from place to place, as I have come to know about in our Province?

MR. FISHER: Perhaps Harold Arnold could answer that question better than I. So far as Ontario is concerned, it is a very rare occurrence. In most provinces it tends to be a rare occurrence.

It is not typical of the practice of optometry in Canada.

THE CHAIRMAN: Is it not one of the professions, one of the services that does lend itself to that kind of thing? The nature of the equipment is transportable.

MR. FISHER: Yes, it would lend itself



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to that. To some extent, the procedures are elective but I think that we must not lose sight of the fact that we are thinking in terms of the terms of reference of the Royal Commission of the best possible service.

THE CHAIRMAN: We are talking about providing personnel. You want more slots in which to put these 15 students you were not able to care of.

MR. FISHER: That is right.

THE CHAIRMAN: We are concerned with the real need.

MR. LANCER: I would like to emphasize, in this connection, that the increase in the number of students, and the slots that are not available are slots that are needed to just maintain the present ratio of optometrists to population.

It has not been based on any assumption of an increase in the utilization of optometrical services, which I think if a comprehensive health care program were introduced, might be expected, at least initially. It has been based on the assumption to just meet the needs as we are, to meet them at the present time, to maintain the ratio of one optometrist to twelve thousand we need to increase, by 1980, the numbers of our students by three times at our College.

Three times the number of personnel enrolled and our problem is that our present total enrolment constitutes the limit of our present facilities.

THE CHAIRMAN: To what extent have you made any progress, or no progress in dealing with a



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university for the College?

MR. BAKER: It is the latter and not the former. No progress.

THE CHAIRMAN: What is the trouble? What is the answer?

MR. BAKER: This is always difficult to answer, but I would say that one of the features here is this continuing and obvious warfare, if you wish, between ophthalmology and optometry. They have not been sympathetic, and especially optometry schools in universities.

THE CHAIRMAN: Does it exist anywhere in the United States or the United Kingdom?

MR. BAKER: No. As we pointed out in our earlier submission all schools that have come into existence since 1925, anyway, have all been university affiliated, or 1935. I am sorry, my memory is faulty on that. About 1935.

COMMISSIONER BALTZAN: All schools in Canada and the United States?

MR. BAKER: We only have the two schools. We were referring to the schools that did come into being after 1935 in the United States, and we were referring to the one or two schools in Australia that have recently come into being within the university system.

My own impression is, as a member of this Board, which has been negotiating on this basis, if we could resolve, or at least neutralize, if one cannot resolve a problem, of the ophthalmological point



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of view towards optometry, the final results of getting into a university would be much simpler.

MR. LANGER: I think I might add to that that part of the problem is that our needs require that we have a university which has facilities to give the basic sciences. Consequently, it must be in a center where there are available clinics, sufficient practising optometrists and clinical staff.

THE CHAIRMAN: Toronto would meet number one and two?

MR. LANGER: Yes, quite definitely.

MR. BAKER: We favour that.

MR. LANGER: We feel we must have available an ophthalmologist on our staff as we do in our present institution.

Now when it comes to discussions with universities as to whether these conditions can be met, as Mr. Baker has suggested, if some of our requirements are met, we find that a stumbling block arises in that ophthalmology's position is that it will not teach optometric students. This poses a problem in that we must have this training to carry out a proper curriculum and we have such facilities in our own College.

We cannot sacrifice the quality of our present training just for the advantages of university affiliation if it is not going to maintain the quality of our training. This has been a serious problem.

COMMISSIONER STRACHAN: In this connection are the admission standards of the College



Baker

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equivalent to the university standards of admission?

MR. LANGER: Yes, they are.

MR. BAKER: And have been since 1937.

MR. LANGER: I should also say, in this connection, with regard to the university, the stumbling block is in eliminating these obstacles and arriving at an initiation of such a program.

Such courses have been developed, certainly, at first class universities but to date we have not been successful in accomplishing this for our College.

THE CHAIRMAN: You are talking about financial support. Does the College qualify to receive the per annum grant made by the Dominion Government to students at universities?

MR. BAKER: No, we do not. We do not at all. We have looked into this, as a matter of fact and we are continuing to look into it but the legislation apparently -- we do not have it in our hands as yet -- is framed in such a way that it does not make it possible for the university foundation, who are the sort of intermediary, apparently, between the Federal Government and Provincial universities to allow such grants.

As we indicated in our brief, and again in our submissions, this College which is set up under a Board of Examiners who, in turn, are responsible to the Province of Ontario, they are appointees of the Government, operate this College and the major resources for the College are the licence fees of the practitioners



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Baker

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4 in the Province of Ontario and the undergraduate fees.
5 which we receive from the people who are enrolled.

6 It is quite apparent, as we have tried
7 to point out in our supplementary brief, that we cannot
8 hope to do our part in educating future people, which
9 we think is part of our responsibility because the
10 fact of the matter is that we cannot approach, in any
11 way, the sums of money that are required to carry on
12 an institution or to extend it to the point where it
should be extended in terms of future needs.

13 COMMISSIONER VAN WART: In answer to
14 the question of Government grants, Government grants
15 take two forms to universities. First is the grants
16 to the institution for administration purposes. That
17 is the one that you have answered.

18 The second type of grant are grants
19 to students in aid of their tuition. Do you qualify
under the latter?

20 MR. FISHER: There are Dominion-
21 Provincial bursaries. If you are referring to these,
22 our students do receive, on occasion bursaries but
23 only where they apply.

24 Alberta, frankly, is the one province
25 that has been very co-operative in that regard. Apart
from that, they get very few grants.

26 THE CHAIRMAN: Without meaning to rile
27 you, is there any notion or do you find any notion or
28 impression of this resistance to university affiliation
29 in the fact some authorities feel that you are more of
30 a trades school than an educational institution?



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Baker

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5 MR. BAKER: Yes. I think this is an
6 opinion which we run into. We are not very happy about
7 people who hold this opinion. On the other hand, we
8 can understand it.

9 We feel that the reason they may very
10 well hold this opinion is perhaps a fault on our own
11 part, in terms of giving the information to people as
12 to what and who we are.

13 It is a funny situation and I am not
14 sure whether I can express it too clearly but because
15 of the nature of this work, and its development you have
16 some, and I am thinking now of the Province of Ontario
17 particularly, you have some of the elements of its
18 early development.

19 You have the shop, and so forth. This
20 is perhaps the thing that most people see. The majority
21 of men who practise, if I may put it this way, like other
22 practitioners they are not readily available; seem to
23 become part of this other group sometimes. Unless we
24 apprise people of this, and put it in a definite form
25 one's first impression of the practice of optometry
26 might be quite different from what it is in fact and
27 we have to live with this.

28 This is a responsibility to get the
29 facts across. While we are pioneering in Canada, to
30 some extent in our part of Canada and trying to get this
university affiliation, the fact is that optometry has
been recognized as a profession pretty well generally,
so that I would have to say that tends to be an isolated
point of view.

MR. BAKER: Yes, I think this is an

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MR. LANGER: When you asked is this attitude evident, I would say yes, I think this type of attitude is apparent with a good proportion of the public who might be unacquainted with the teachings of our training.

When there has been an examination of the curriculum and discussion on this level, I do not think it poses a problem. Of course, a school of optometry has existed in the University of Montreal for many, many years.

THE CHAIRMAN: In the Province of Quebec, then, what is the situation? You have a school with the university?

MR. LANGER: Yes.

THE CHAIRMAN: What happens to the graduates?

MR. BAKER: Where does he practise?

THE CHAIRMAN: How does he get into practice, having graduated?

MR. BAKER: He goes through the regular Provincial licensing body.

THE CHAIRMAN: Medical or optometrical?

MR. BAKER: Optometrical.

COMMISSIONER BALTZAN: Does this school provide an ophthalmologist?

MR. BAKER: I cannot speak for them, but I believe they are having their problems.

MR. FISHER: I believe they bring one in from the United States on certain occasions to lecture during the school year.



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Baker

MR. LAMBERT: When you asked is this attitude evident, I would say yes, I think this type of attitude is apparent with a good proportion of the public who might be disappointed with the teachings of

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COMMISSIONER BALTZAN: The University cannot use its own influence to supply that particular teacher?

MR. FISHER: Apparently not. I am not familiar with that situation, Dr. Baltzan. I was going to point out, Mr. Chairman, that optometry has been established as a satisfactory curriculum by some of the leading universities in the United States. They are not second-rate institutions and I think this should be borne in mind as well.

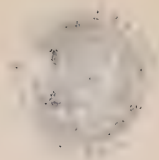
Ohio State University. University of California, for two, Indiana University is a third one.

COMMISSIONER VAN WART: You say that your facilities for teaching are such that you have to turn down applicants at the present time. In rectifying this condition do you recommend expansion of your present institution or would you like to have institutions created in affiliation with a university? New institutions or what are your ideas?

MR. FISHER: I believe in our original brief we specified that it would be probably the best procedure to expand the present ones, to a certain level, and then following that other institutions would be opened up; the level being something of the nature of an enrolment of approximately 200 students, total.

At the present time our enrolment is half of this, or a little bit less.

COMMISSIONER VAN WART: Do you feel that schools for teaching should be created in conjunction with universities?



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COMMISSIONER VAN WART: Do you feel that

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with universities?



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MR. FISHER: Yes.

COMMISSIONER VAN WART: Not open schools to become affiliated?

MR. FISHER: We would like to become affiliated too.

THE CHAIRMAN: Would you accept this, from what you have said to us, that if you had an enrolment of 200 at your school and you were affiliated with a university that would take care of the demands in Canada for the foreseeable future?

MR. LANGER: No sir. Projections originally are based on the assumption that at the present time our schools produce about 60% of the graduates in Canada and the school in Montreal about 40%.

Under a total enrolment, in order to continue our practitioners at the same present ratio, we would need an enrolment of 213 in the academic year 1966 to 1967. That is three years from now. And in order, of course, to double our enrolment, our facilities would immediately have to be expanded. We are in a position where we just cannot expand our facilities so unless measures are taken there is certainly no hope of maintaining the ratio of practitioners at their present level.

We will have to continue to turn away students beyond the numbers that we presently enroll.

COMMISSIONER VAN WART: You have taken into consideration the upsurge in the population?

MR. LANGER: Yes.

COMMISSIONER VAN WART: Those who have



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the university level at the present time and will come into your field in a very few years?

MR. LANGER: Yes. We based it on an attrition rate of 3%, which is our present attrition rate and on a population growth, which was projected by the Royal Commission on Canada's economic affairs.

This would mean that our present school should be doubled within the next three years and, presumably, that a further school should be in operation some six or seven years from now.

THE CHAIRMAN: Thank you very much gentlemen.

MR. BAKER: Thank you. We appreciate the thought you have put behind these questions. If we can be of any further help, we will be glad.

THE SECRETARY: The next submission is from the Optometrical Association of Ontario. This will be known as exhibit R-9.

--EXHIBIT NO. R-9: Submission by the Optometrical Association of Ontario.



SUBMISSION OF

THE OPTOMETRICAL ASSOCIATION OF ONTARIO

APPEARANCES:

Mr. R. Thomson
Mr. E. Woodruff
Mr. J.W. Duffy

THE SECRETARY: Mr. Thomson will introduce his group.

MR. THOMSON: Mr. Chairman, and members of the Commission, I would like to introduce the members of my delegation, but before I do so, I would like to clarify a question that was asked and that is why there are supplementary briefs presented by the Board and our Association.

The Board of Examiners are appointees of the Province of Ontario and the Association is a voluntary professional group. Therefore, the organizations differ, but I would like to endorse the presentation that you have just heard.

Since we presented the separate brief, we felt that it was necessary to make our supplementary presentation separately. With this introduction, I would like to introduce then the members of the delegation.

The administrative director of the Association, James Duffy. The Vice-president of our Association, who will give you the summary and conclusion of our supplementary brief, Emerson Woodruff.

MR. WOODRUFF: Before I commence, I had two questions in the previous summation on which I have some information which I think I might read to you, if I may.

I will not make it long, but the question was asked about the set-up of the administration of licences and in Great Britain in 1958 there was passed in the House of Commons of Great Britain, the Opticians' Act. In Great Britain there were two types of optometrists, an

REPORT OF THE
THE OPTOMETRIC ASSOCIATION OF ONTARIO

introduction is given.

MR. TROTT: Mr. Chairman, and members
of the Commission, I would like to introduce the members
of my delegation, the before I do so, I would like to
clarify a question that was asked and that is why these
representatives are being presented by the Board and not
the Association.

The Board of Examiners are representatives
of the public interest and the Association is a
voluntary professional group. Therefore, the Association
feels that it would like to endorse the presentation and
you have that right.

Since we presented the appropriate brief,
we felt that it was necessary to make our supplementary
presentation separately. In this introduction, I would
like to introduce each of the members of the delegation.
The Chairman, Mr. [Name], The Vice-President of our
Association, Mr. [Name], who will give you the summary and conclusion
of our supplementary brief, Mr. [Name], Mr. [Name],

MR. [Name]: Before I commence, I had
two questions in the previous question to which I have
some information about I think I might read to you, if
I may.

I will now make it clear, but the question
was asked about the step-up of the administration of licenses
and in Great Britain in 1962 there was passed in the House
of Commons of Great Britain the Opticians' Act. In Great
Britain there were two types of optometrists, an



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ophthalmology optician, which is what we call in North America an optometrist, and then there is the manufacturing optician which is the equivalent of our optician here. The Opticians' Act created a general organization which consisted of 24 members, and these people administrated all affairs, in this regard in Great Britain. This group consists of five registered ophthalmology opticians, two chose to represent the registered manufacturing opticians, six nominees of examining bodies -- these are people from the various institutions of ophthalmology opticians teaching in Great Britain and the remaining six are ophthalmologists.

It is very interesting to note that in their published regulations that this body specifically delegates the authority to an ophthalmologic optician to recognize and refer diseased eyes. So with the group composed of the people that I have mentioned, they obviously feel that these people are competent to do this, and, therefore, I would infer our own competence from this because our training is of equal calibre. The only thing where they have progressed beyond, and this is one reason why I introduced this, one of our recommendations is that we have facilities available to us to enter hospitals to meet the standard of our training, and apparently the National Health Service in Great Britain has facilities to do that. The relationship between these groups is very good and since it can be done there, we are reasonable people and I think we could assume that we could follow the same course here.

COMMISSIONER BALTZAN: Do you have that



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here, anywhere in Canada?

MR. WOODRUFF: We have not that here, anywhere in Canada.

Optometric training would be facilitated by some hospital clinical training in pathology of the eye.

The inference here is that the training in pathology is efficient as to the number of cases seen by the undergraduate.

THE CHAIRMAN: Where do they get training now?

MR. WOODRUFF: Through welfare clinics mostly, and some people use their own undergraduates.

THE CHAIRMAN: How do you propose that, how do you see that as a practical thing, hospital facilities being made available? Is that where you want to get some of your clinical material?

MR. WOODRUFF: Yes; and also we believe there should be more utilization of optometrists in hospital situations.

Being personal, I am employed in a hospital, and the staff there seems to be satisfied with my work. In the area that I am in there was no other form of eye care.

THE CHAIRMAN: What appears to me in this initial stage is -- I can be wrong -- I thought the basic field of optometry was in the matter of refractions.



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MR. WOODRUFF: Well, there are a good number of hospitals where there are a tremendous number of refractions being performed.

THE CHAIRMAN: And, ordinarily, hospitals, as I know them, you don't go to hospitals for refractions, you go because of some physical illness.

MR. WOODRUFF: There is a hospital in my region where I have taken patients who are indigent, I have driven them 70 miles because I thought they needed ophthalmological care. In a morning an ophthalmologist may examine 75 children. Now, no matter how competent he is able to do this number of examinations in the morning, these children are not getting what I would feel is the best of care. Those that he cares for adequately take a greater proportion of the time and the others are shoved off for future times when he has the time to take care of them. But these are ophthalmologists doing these refractions, and most of this care is refractive care.

THE CHAIRMAN: You wouldn't take a child 70 miles merely for a refraction?

MR. WOODRUFF: No. The two I took there were for examination of a pathological condition. But the balance that were there, a good proportion of them were not for pathological care, they were for refraction care.

THE CHAIRMAN: And they were there because they were indigent?

MR. WOODRUFF: That is right, and it was my feeling they were not getting the best of care



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4 simply because the situation in this particular place
5 did not permit the individual, who was a very good man,
6 time to take care of them properly.

7 THE CHAIRMAN: That is another problem.

8 MR. WOODRUFF: It is the problem of
9 employing enough personnel. I know in this particular
10 instance there are people who would gladly give of their
11 time if they were permitted to enter that hospital, they
12 would do it without remuneration, but they are not
13 permitted to do refraction.

14 COMMISSIONER BALTZAN: You were doing
15 optometric work in a hospital?

16 MR. WOODRUFF: Yes, refraction.

17 COMMISSIONER BALTZAN: You say others
18 want to do it?

19 MR. WOODRUFF: Yes, a good number of
20 others. In this particular instance I know that the
21 ophthalmological society offered their services to this
22 hospital, and there was one man doing the work and who
23 knew what the work was and would have welcomed their
24 participation, but he was not permitted to prevail. This
25 is a different hospital. I am in one, and I am referring
26 to another. This is an Ontario hospital I am in.
27 It is a government hospital. The other hospital to which
28 I was speaking is a public hospital with an out-patient
29 department, general hospital.

30 COMMISSIONER BALTZAN: That is where I
thought you were.

MR. WOODRUFF: I am not in the general
hospital.



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To return to your question, Mr. Chairman, I think there is a large number of hospitals throughout the Province of Ontario where this condition prevails, where it is not for lack of even time to participate, it is excluded.

MR. THOMSON: There is in Hamilton, with which I am familiar, a general hospital. They have an out-patient clinic to which the indigents do go for refraction, and the same conditions prevail, where there is a tremendous amount of work being done by one or two men. It would seem obvious that if at least these people are competent to do this type of work and have volunteered to do it, they should be allowed to do this, not only to help the situation, but also to improve the training and detection of pathological conditions.

COMMISSIONER GIRARD: Do you mean a highly qualified medical doctor is used to do something that a highly qualified person could do well?

MR. THOMSON: Bluntly, yes.

MR. WOODRUFF: The only exception I would take there is that he is highly qualified in pathology and his work is far more valuable to society, and we haven't any desire to encroach on their field at all. We fully realize their necessity and wish them well.



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at all. We don't want their necessity and wish them

well

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INTRODUCTION

This is a supplement to the main brief submitted by the Optometrical Association of Ontario, to the Royal Commission on Health Services in Toronto, Ontario, May 11, 1962.

Its purpose, in common with that of the original submission is to assist you in carrying out the instructions by which you were commissioned "to enquire into and report upon the existing facilities and the future need for health service for the people in Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians".

Optometry evolved to its pre eminent position as the specialists in vision care because of the fulfilment of public need: We are specifically licensed in every province to do so: therefore, we feel the Commission under its instruction cannot help but make specific recommendations as to the utilization of optometrists in the provision of the best possible health care for the people of Canada.

This supplement discusses aspects of the main brief which we feel bear repetition and emphasis, comments on opinions expressed during the hearings in Toronto, which if not questioned might be accepted by



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default, deals with matters not touched on in the original submission, and results in conclusions and recommendations, some of which have already been given and others of which are new.

It should be noted that the numerical page references given throughout this brief, refer to the page numbers of the official transcripts of the hearings.

Our recommendations are as follows.

1. Complete vision care should be included in any comprehensive health program.

2. Existing pre-school and school health care programs should be extended to include full complete vision care testing by qualified practitioners.

3. Health departments should endeavour to make the public more aware of the need for early and regular vision examination.

4. Present welfare programs should be extended now to include complete vision care for all those unable to obtain it otherwise.

5. Every effort should be made to establish and maintain effective liaison between the medical and optometric professions. We are prepared to co-operate fully in giving effect to this recommendation.

6. Hospital facilities should be made available to assist in optometric study and training.

7. Any extension of present health care plans coverage should include complete vision care services to be available from either ophthalmological or



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4 optometric sources.

5 8. Professional autonomy should be respected
6 in all health programs; optometrists should be included
7 on advisory or other committees dealing with vision
8 care services.

9 Our summary of conclusions are as
10 follows.

11 1. Vision care is part of health care and
12 the much greater portion of vision care has to do with
13 refractive errors and problems of binocular vision.

14 2. Pre-school and school health programs
15 generally do not provide adequate vision care tests.

16 3. The preventive aspects of vision care
17 are not widely recognized with possible serious results
18 to sufferers from unsuspected vision problems.

19 4. There are possible "catastrophic"
20 results which arise from inadequate vision care.

21 5. Optometrists are trained to detect cases
22 of pathology and do refer such cases to the medical
23 practitioner.

24 6. The extent of training and professional
25 competence of optometrists is not fully realized by the
26 medical profession.

27 7. Optometric training would be facilitated
28 by some hospital clinical training in pathology of the
29 eye.

30 8. Present health insurance plans tend to
restrict vision care benefits and lead to possible
medical control of non-medical health professions.

9. Extension of present insurance plans



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Our summary of conclusions are as follows.

1. Vision care is part of health care and the much greater portion of vision care has to do with refractive errors and problems of binocular vision.
2. Pre-school and school health programs generally do not provide adequate vision care tests.
3. The preventive aspects of vision care are not widely recognized with possible serious results to sufferers from unsuspected vision problems.
4. There are possible "catastrophic" results which arise from inadequate vision care.
5. Optometrists are trained to detect cases of pathology and do refer such cases to the medical practitioner.
6. The extent of training and professional competence of optometrists is not fully realized by the medical profession.
7. Optometric training would be facilitated by some hospital clinical training in pathology of the eye.
8. Present health insurance plans tend to restrict vision care benefits and lead to possible medical control of non-medical health professions.
9. Extension of present insurance plans



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4 will not "ensure that the best possible care is available
5 to all Canadians".

6 1. In any consideration of what constitutes
7 "the best possible health care" and how to ensure that
8 it is "available to all Canadians" it must be established,
9 presumably, whether or not "vision care" is part of health
10 care and, if it is, what part optometrists should play
11 in providing it. We should state at the outset that
12 it is the view of the Ontario Optometrists that vision
13 care is an essential part of "the best possible health
14 care" and optometrists are essential to its being
15 "available to all Canadians". We are, frankly,
16 concerned that vision care might not be so regarded or
17 that optometrists may not be given their rightful place
18 in its provision if included. In either event the
19 public must be the loser.

20 2. There can be no question that that part
21 of vision care which is medical or surgical in nature
22 should and will be included in any health care plan.
23 This, however, is only part of vision care. By far the
24 greater part has to do with refractive errors and
25 problems of binocular vision in both adults and children.

26 3. Children are particularly likely to
27 suffer unduly from any inadequacy of vision services,
28 if for no other reason than that the eyes play such an
29 important part in the learning process and lack of care
30 can seriously effect the general well-being of the child.

4. Commissioner Girard asked the
Ophthalmologists if all children were examined to
ensure that they commenced school with proper visual



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ability. (Pages 9724-25). The answers indicated that present system discovers only those with disease or obvious defects such as squints.

5. The Orinda (California) Study records an incidence of pathology of 1.12% and the Hamilton (Ontario) study one even lower, whereas the incidence of non-pathological vision problems ranged increasingly from 18% at age 5 to 32% at age 15. We believe, therefore, that our present system is gravely inadequate and likely to remain so until regular vision examinations of pre-school and school children by qualified practitioners become part of the health program. It follows that such care should be part of any comprehensive health plan.

6. Only Optometry and Ophthalmology have the professional skills and training to utilize those tests which provide proper screening and diagnosis and we wish again to stress that the Commission should examine all available means to extend the benefits of early vision examination to the children of Canada. To provide this service would not require any great additional organizational expense. The county health units, already in being, provide the vehicle and inclusion of an optometrist in the units is all that is required to provide the means.

7. At the other end of the population scale there are the aging citizens. They are also specially victims of any inadequacies in health and welfare services. Vision care to them is essential to a full enjoyment of declining years and, in many cases, prolongs



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5 their sphere of usefulness to the community in which they
6 live; its inclusion in health plans is necessary if this
7 ever increasing part of the population is to be fully
8 assured of "the best in health care".

9 8. Beyond the special need of special
10 groups, however, is the question of inclusion of vision
11 care for the benefit of the public as a whole. The
12 need for vision care is not always accompanied by signs
13 or symptoms readily recognized by the patient and in
14 relatively few instances is it accompanied by pain or even
15 mild discomfort. All too often therefore it passes
16 unnoticed or may even be deliberately overlooked, parti-
17 cularly when the family budget is strained. Thus, one of
18 the most important aspects of treatment, early diagnosis,
19 rarely assumes its rightful place in vision care while
20 its preventive aspect is overlooked by almost all but the
21 practitioner himself.

22 9. The profession of Optometry is vitally
23 concerned with preventive vision care which in its treat-
24 ment aims at the achievement of optimum visual efficiency
25 as well as dealing with the problem of impairment. Pre-
26 ventive optometry has its application in (1) promoting
27 optimum visual efficiency; (2) early diagnosis and treat-
28 ment (with referral if necessary;) (3) limiting disability
29 and blindness; and (4) rehabilitation. In Appendix I,
30 some general principles of preventive care are presented
to amplify this concept.

10. Health care plans and services are
inevitably concerned with preventive as well as curative
measures and we do not regard vision care as greatly, if



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any, different from other aspects of health care in this context.

11. If we appear to labor the point of similarity between vision care and other health care benefits, it is largely because of a comment concerning the philosophic approach to the total problem, made by the Chairman of the Commission during the hearing of our original submission: "while a person is able to absorb what is a recurring, what may be recurring but an excess item of expense, what really damages the individual and the State is the difficulties which arise from a catastrophic illness or condition. Have you anything to say as to how the practice of optometry, which, if I am correct - maybe I am not - doesn't come within this catastrophic definition; how it would fit into a comprehensive program?"

Why it would necessarily fit in? (Page 9692, lines 11-18)

12. Our reply briefly expressed at that time concerned itself with the question as asked but it is respectfully suggested that the demand for improved health care plans and services on this continent is based more on the day to day expenses of health care than on the relatively infrequent catastrophe caused by either sickness or accident.

13. People have become premium or budget minded and so comprehensive health care is what they demand; not catastrophe insurance. Catastrophe coverage is only one aspect of the care for which they are looking. In this context, vision services become a desirable, even necessary inclusion because the incidence of vision problems is high and the need for care



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generally recurrent if the patient is to receive optimum satisfaction from treatment. In this respect it differs little from dental services.

14. Without attempting to appraise the correctness or otherwise of present day health care plans, the trend of such programs is to make them more comprehensive, not less, and while there is discussion about catastrophic health care plans, in fact the plans offered and in operation today go far beyond that type of programming. It is with these developments that Optometry has concerned itself both from the point of view of the development of optometric practice and that of the welfare of these people who require vision care services. We repeat our belief that vision care services cannot reasonably be omitted from a comprehensive program for health care.

15. Finally, "catastrophe" is a relative term in certain respects. We believe that in the case of vision care it can be applied in the following sense to those who:-

(i) through lack of financial ability,
need the care but do not obtain it, or
obtain it by foregoing some other need.
We have previously indicated some segments of the population where this might apply, but do so again due to our strong feeling in the matter:

(a) indigents

(b) Mother's allowance recipients

(c) old age and other pensioners



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The need for a comprehensive health care plan including vision care for this group seems obvious.

(ii) through lack of knowledge or understanding, do not seek the care.

Included in this group will be many who, lacking symptoms, are falsely sure that their vision is good.

The great value to this group of a plan which includes vision service is that they will become more aware of the service itself.

(iii) require frequency of care not usually recognized as necessary. (We refer you to our concept of preventive care). The frequency of eye examinations generally bears no relationship to the optimum time that should elapse between such examinations. It would be possible to achieve this optimum only through public education and the right to seek care at all times being available under a health scheme.

16. Possible "catastrophic" results within all groups include e.g. undetected pathology and consequent lack of referral for treatment; non-discovery of amblyopia which can be prevented by early care, or its effects reversed if discovered in time. In either case irreparable damage can result from lack of or long delay in seeking care.

17. A comprehensive Health Program would make all groups much more aware of the need for care,



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would make the care available when sought and greatly increase the number of those seeking care before, instead of after, symptoms occur. We feel this to be the best means whereby, particularly, the children of Canada will receive adequate vision care.

18. In considering the inclusion of vision care in a health care program, there is one matter to which reference must also be made. Medical and surgical treatment of the eyes are inevitably included and in many instances, a refraction could justifiably be regarded as part of a medical eye examination. This means in effect that the exclusion of a refraction benefit does not prevent its being performed but merely excludes the optometrist from performing it.

19. There is an inherent danger in this, that existing patient-practitioner relationships are affected; always to the detriment of the optometrist and frequently to the financial loss of the patient, who may find himself travelling to a distant centre for an examination by an ophthalmologist which could have been provided in his own community by the resident optometrist.

20. It is thus not only difficult to justify the exclusion of vision care from the best possible health care but it is in fact very difficult to exclude it at all. The real problem is to include it in such a way that the "best possible" care is provided and "is available to all Canadians".

21. Might we at this stage refer you to the definition of the practice of optometry as set out in paragraph 13 of our original submission:-



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- (a) To examine for the presence or absence of active disease processes within the eye and its adnexa and when such exists to advise the patient of the need for consultation with a physician. In cases where the condition concerns the eye alone, the patient is usually referred directly to an ophthalmologist.
- (b) To ascertain the presence or absence of optical defects in the eyes and when such exist to advise, to prescribe and fit appropriate optical devices for the correction of such defects.
- (c) To determine the presence or absence of defects in the sensory characteristics and motor functions of vision and when such exist to prescribe appropriate orthoptic treatment or visual training exercises except in those cases requiring treatment by drugs or surgery.
- (d) To appraise and advise concerning the environmental factors which pertain to good vision, the health of the eye and the use of the eyes in such environments and to prescribe any means of protection to the eyes or means of enhancing the usual functions in such cases.



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4 22. We believe that this definition
5 establishes optometry's place amongst the health profes-
6 sions in such a way that the exclusion of optometrists
7 from any plan including vision care would be not only
8 unjust but unwise and a very real loss to the public
9 whose interest is paramount in the matter. We believe
10 also that it establishes optometry's right to be regarded
11 as a separate profession however specialized or "limited"
its field may seem to other professions.

12 23. As one examines the reports of Commis-
13 sion hearings it appears that, in many minds, health
14 care and medical care are regarded as interchangeable
15 terms and medical, dental and nursing services are
16 regarded as the health care team with perhaps, certain
17 para-medical personnel being included as technical assis-
18 tants. Optometrists seem to be grouped together with
19 all those practising in the health field outside of this
team.

20 24. We believe that this grouping both
21 stems from and leads to an incorrect assessment of opto-
22 metry's professional status and practice; an assessment
23 which is summed up by the Canadian Ophthalmological
24 Society statement that "the only adequate eye care is
25 medical eye care" followed by Dr. Marshall's opinion
26 that nothing serious would result to the people of Canada
27 if there were no optometrists (Page 9710-9711 of the
transcript).

28 25. Since as high a total as 70% of all
29 Canadians seeking vision care obtain it from optometrists,
30 it is hardly necessary to say that, if there were no



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4 optometrists, the present distribution of ophthalmolo-
5 gists and short supply of trainees for that profession
6 could result in a deterioration in service in three ways:

7 (a) a great number of eye examination
8 never being performed.

9 (b) an increase in work load which
10 would be a physical impossibility for
11 the ophthalmological profession to
12 carry.

13 (c) the transfer of time from medical
14 to refractive care could conceivably
15 lead to a lessening of the practitioner's
16 skill in surgery and care of eye disease.

17 This can hardly be regarded as "nothing serious".

18 It is interesting to note incidently
19 that, in 1959, of more than 5,000,000 vision examinations
20 in Britain 82% were performed by ophthalmic opticians,
21 (optometrists).

22 26. Dr. Marshall's replies to certain
23 questions by Commissioner McCutcheon are interesting,
24 (Page 9709, line 22 to 9710, line 10), both in their
25 context and their implications:

26 COMMISSIONER McCUTCHEON: "Dr. Marshall,
27 would you like to expand on the second
28 statement, both to your brief and
29 summary of recommendations: 'We believe
30 that the only adequate eye care is
31 medical eye care'.

32 DR. MARSHALL: "Any eye care or any
33 health care on any part of the body, in



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our opinion, is medical".

COMMISSIONER McCUTCHEON: "Then would you abolish the profession of Dentistry? You say health care on any part of the body is medical, do you include the dentist?"

DR. MARSHALL: "I am speaking from the point of view of medical but as regards dentists, I would not exclude them at all because their training, as far as their limited field is concerned, it really includes medical, they have had medical training."

Following this came Dr. Marshall's admission that he was not familiar with the training of optometrists (Page 9711, line 19-27).

DR. MARSHALL: "We have confined our study to the training of ophthalmologists. We have limited our studies and observations to our own field, we have not made a study of the training of any other group."

COMMISSIONER McCUTCHEON: "Surely you must be familiar with the training?"

DR. MARSHALL: "Not sufficiently well familiar to express an opinion to the Commission on which they might base conclusions."



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training been as thorough as it might have been, he would have realized that what he had said of dentists training was, within their own field, equally true of optometrists. One might almost be led to conclude therefore that a better knowledge of optometric training and practice could change Dr. Marshall's opinion of the value of optometric services to the public.

28. The optometric student spends approximately one third of his time on the medical aspects of eye care, taught by medical personnel. The training in recognition of diseases of the eye and systemic disease revealed in the eye beings with basic biology, anatomy, physiology, histology and embryology. This is developed by extensive study of the nature of disease and pathological processes in the body generally and the eye in particular and the studies are augmented by clinical cases. In Ontario, this training results in thousands of optometric patients being referred annually for medical diagnosis and treatment. Appendix II outlines optometric differential diagnosis. This represents the optometrist's approach to any vision problem. It will be noted that the optometric problem is considered only after consideration has been given to the elimination of pathological conditions.

29. Dr. Marshall is not alone in his lack of detailed knowledge about the optometric profession. Dr. G.E. Wodehouse, Chairman of the Executive Sub-Committee of the C.M.A., in reply to a question concerning the training and qualifications of optometrists, asked by Commissioner Baltzan, stated "specifically, this is an



...been as thorough as it might have been, he
would have realized that what he had said of ophthalmic
training was, within these few lines, merely a part of
optometric. One might almost be led to conclude there-
fore that a better knowledge of ophthalmic training and
methods could be gained by a study of the
value of ophthalmic services to the public.
The ophthalmic service is a part of
merely one thing in the world of the medical service. It
eye care, taught in medical schools. The training in
recognition of the signs of one and various diseases
revealed in the eye helps with brain biology, anatomy,
physiology, psychology and everything. This is developed
by a knowledge of the nature of disease and pathology
and processes in the eye, brain and the eye.
Particular and the studies are concerned by anatomy
cases. In ophthalmic, this training is given to thousands
of ophthalmic doctors, ophthalmic assistants, etc.
medical, dental and treatment. There is no ophthalmic
physician, ophthalmic assistant, etc. The ophthalmic
system that a patient is to be treated with. It will
be noted that the ophthalmic problem is considered only
when necessary and then it is to the ophthalmic
of ophthalmic conditions.
The Medical is not alone in his lack of
realized knowledge about the ophthalmic profession. Dr.
C. J. Webber, Chairman of the American Optometric Association
of the A.M.A., in reply to a question concerning the
training and qualifications of optometrists, asked by



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4 area in which I am not familiar" (Page 10179, line 10).
5 30. Dr. Wodehouse, in other comments on the
6 subject, said ".....there are undoubtedly optomet-
7 rists in this city and others who recognize there is
8 something wrong other than just refraction error and do
9 refer patients, quite ethically and properly to an eye
10 doctor." He then went on to say ".....there are
11 optometrists who have not these recognized levels of
12 training.....these, Sir, are the people who cause us
13 concern....."(Page 10178 of transcript). Such an
14 opinion might be held at almost any time about any
15 profession anywhere. Improvements in training, tech-
16 niques, practice are constant; today's students benefit
17 from a wider range of knowledge than did their fathers;
18 in any generation some are more gifted than others.
19 Thus, variances in standards of competency are to be
20 expected. The important thing is that modern optometrists,
21 like modern physicians, are highly trained within their
22 own field and entirely competent in the practice of their
23 profession.
24 31. No profession should expect to be above
25 criticism but valid criticism at this level should be
26 constructive in nature and purpose and based on a full
27 knowledge of all the facts. We believe that the public
28 would benefit by closer liaison between medicine and
29 optometry so that such knowledge can be brought about.
30 We would welcome any attempt to establish this liaison.
In our opinion co-operation between the Health Professions
is desirable and necessary if the best possible health
care is to be made available to all Canadians.



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32. To support this opinion, we quote from a paper "What can an optometrist contribute to the Early Recognition of Glaucoma" presented before a meeting of the American Association of Optometrists by P.C. Kronfield M.D., Professor of Ophthalmology, Illinois Eye and Ear Infirmary, University of Illinois College of Medicine: ".....it is fully realized that in actual figures the Optometrist makes a greater contribution to the early recognition of glaucoma than does the Ophthalmologist. Undoubtedly, Optometrists are in contact with a greater segment of the population in the United States than is the body of Ophthalmologists. The number of cases of glaucoma detected by optometrists must be very much in excess of those detected by Ophthalmologists. Consequently "a more accurate wording of my title would be 'What can the Optometrist do to Contribute More to the Early Recognition of Glaucoma?'"

33. In this statement are all the elements to support our desire for co-operation with the medical profession. There is a recognition of the fact that optometrists can and do detect pathological conditions and optometrists do provide a high percentage of all vision examinations; there is the reasonable assumption that knowledge may be increased and results bettered; there is implied the willingness to assist in increasing knowledge so that the public may be better served and there is a clear indication why vision care and the optometrist should be part of any comprehensive health care program.

34. That optometry and ophthalmology can



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4 work together for the common good is abundantly clear.
5 Studies such as those undertaken in Orinda, California,
6 and the screening program in Hamilton, Ontario, prove
7 the value of co-operative effort by the two groups.
8 Unfortunately however, this happy relationship is all
9 too rare and one area of co-operation therefore is closed
10 to us which, if open, would greatly facilitate the
11 training of our students. We refer to the hospitals.
12 35. Whatever may be said about optometric
13 training, there can be no gainsaying that clinical work
14 in hospitals would benefit the optometric student in
15 his studies of medical subjects and we believe that such
16 work should be part of our training. Since hospitals
17 are supported by public funds and since public welfare
18 is at issue, there is reason for suggesting that such a
19 course of action is not only justified but should be
20 carried on.

21 I would like particularly to bring to
22 your attention the following paragraph:

23 36. As a profession, optometry is vitally
24 concerned about its relations with medicine. We recog-
25 nize the unique position of the medical profession in
26 the health field and we understand, therefore, the
27 concern of the College of Physicians and Surgeons about
28 the standards of training and practice of other groups in
29 the healing arts (Transcript Pages 10798-10802). We
30 believe that this concern, however, should not be trans-
lated into medical control of those other groups. In
the event, therefore, of government sponsored health
plans being implemented, adequate safeguards should be



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provided to ensure the autonomy of the health care professions.

37. Strangely enough, the extension of Physicians Services Incorporated, Associated Medical Services, Windsor Medical Services and other similar plans; including, to a degree, insurance company health plans; can result in a form of overall medical control such as we suggest is not desirable. These plans have the effect of establishing a third party, medically oriented and governed, which controls every health service through the application of the benefits and any limitations or exclusions in the plans. In this way, non-medical practitioners in specialized fields can be eliminated quite effectively. This is already happening to optometry, to a degree, in areas where such plans are widely sold.

38. We believe, therefore, that any health plan which provides a service or benefit which can be performed by two or more licensed professions should be available from both or all those professions. On any other basis the right of the patient to choose his own practitioner is interfered with and the sponsors of the plan become a party to alienating that right. As applied to vision care services it also results in the service becoming less instead of more, readily available or of requiring the patient to pay a double fee to obtain it.

39. In the original submission of this Association, we expressed the opinion that "serious inadequacies exist under present conditions in the field of health care services." One of these inadequacies is

provided to ensure the autonomy of the health care

professionals.

27. Accordingly, the attention of

physicians, nurses, hospitalists, associated medical

services, clinical medical services and other similar

services, including, but not limited to, hospitalists, should be

placed on a level of medical control

such as we suggest is not desirable. In the past have

the effort of establishing a policy board, particularly

extended and advanced, which controls every health

service through the application of the medical and any

limitations or restrictions in the field. In this way,

non-medical health care in medical fields can be

eliminated with effectiveness. It is already happening

to obstructive, to a degree, to what health care

wisely said.

28. We believe, therefore, that any health

plan which provides a service of health care can be

performed by two or more persons, should be

available from both or all those professionals, in any

other field the right of the patient to choose his or

his physician is guaranteed with the open air of the

plan become a key to eliminating the right of the patient

to choose his or her physician. It also results in the service

becoming less than of more, really available to of

requiring the patient to pay a fee to obtain it,

association, we express the opinion that "serious

institutions exist under present conditions in the field

of health care services." One of these institutions



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4 the lack of a comprehensive program of vision care at
5 practically all levels of service, or even apparently a
6 recognition of the need for one. Plans which, at
7 present, include any provision for this benefit do so on
8 such a restricted basis that their extension, as advo-
9 cated by some groups appearing before the Commission,
10 would not change our concern therefore about the need to
11 provide a vision care program for Canadian children,
12 older Canadians and all those who needing care do not
13 realize the danger of delay in seeking it. We believe
14 that only a government sponsored plan can be expected to
15 meet this need. It is our recommendation therefore that
16 all steps be taken to ensure that such a plan be insti-
17 tuted and that optometrists be appointed to serve on any
18 committees, departments or units providing vision care
19 services. A secondary recommendation might be that all
20 efforts should be made to improve present programs as
21 quickly as possible.

22 40. The foregoing is respectfully submitted
23 with the earnest desire of Ontario optometrists to
24 assist the Commission in arriving at an accurate assess-
25 ment of the need for vision care and the role of opto-
26 metrists in a comprehensive health care program.'

27 41. The members of the Optometrical Associa-
28 tion of Ontario wish to assure the Commission that they
29 are prepared to do all that lies within their power to
30 do whatever "will ensure that the best possible care is
available to all Canadians."



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APPENDIX I

Some general principles of preventive visual care:

- I. Promoting Optimum Visual Efficiency
 1. Definite programs of ocular hygiene.
 2. Public information concerning the care and proper use of the eyes.
 - Teaching good visual habits.
 3. Development and application of proper and adequate lighting.
 4. Physiologic and clinical analysis of visual tasks in school, industry and business. Adapting visual performance to these.
 5. Special studies and recommendations with respect to reading, movies, television viewing, driving, flying, etc.
- II. Early Diagnosis and Treatment
 1. Public and professional education towards screening programs. Getting people to present themselves in the presymptomatic stage.
 2. Development and application of rapid, effective and practical screening tests.
 3. Periodic complete visual (and general) examination.
 4. Gathering statistical and other clinical data about the causes of visual impairment and their earliest manifestations.



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5. Professional responsibility in complete follow-up of ocular symptomology by referring patient for specialized help if such is indicated and convincing the patient of the necessity for such consultations.

III.

Limiting Disability and Blindness

1. Prevention of diseases likely to lead to blindness.
2. Early recognition and treatment of diseases likely to lead to visual impairment.
3. Public education to safety measures in preventing ocular injuries.
4. Industrial and school vision preservation programs.
5. Periodic, regular ocular examinations by competent professional personnel.

IV.

Rehabilitation

1. Specific techniques in aiding the vision of the patient with subnormal acuity.
2. Evaluation of vocational, social and economic implications of subnormal vision and blindness.
3. Adapting the professional and community resources to the specialized needs of this group of patients.
4. Psychologic implications of



Professional responsibility in
complete following of current symptoms
by referring patient for specialized
help if such is indicated and contacting
the patient of the necessity for such

Identifying Disability and Blindness

1. Recognition of diseases likely to
lead to blindness
2. Early recognition and treatment of
diseases likely to lead to visual
impairment
3. Public education to safety measures
in preventing ocular injuries
4. Industrial and school vision pro-
grams
5. Early identification of ocular examina-
tions by competent professional person-
nel

Rehabilitation

1. Specific techniques in aiding the
vision of the patient with subnormal
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2. Evaluation of vocational, social
and economic implications of subnormal
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3. Adapting the educational and commu-
nity resources to the specialized needs
of this group of patients
4. Psychologic implications of



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intelligence, motivation, temperament
and ability of patients to participate
in rehabilitation programs.

5. Specific rehabilitation techniques
for the strabismic patient, the poor
reader, color blind, night blind, etc.



intelligence, motivation, temperament
and ability of patients to participate
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2. Specific rehabilitation techniques
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reader, color blind, night blind, etc.

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APPENDIX II

Optometric Differential Diagnosis

1. Case History
2. Patient Observation
3. External and Internal Ocular Examination
4. Evaluation

Tentative Diagnosis

Is it an optometric problem?

Is it non-optometric problem?

Selection of Suitable Tests

1. Refractive

2. Phorias

3. Ductions

4. Special, etc.

1. Primarily an ocular disease

2. Primarily a systemic disease

3. Primarily a dental disease

4. Primarily a psychogenic disease

Evaluation of Data

Is referral required?

Differential Diagnosis

1. Refractive problem

2. Binocular problem

3. Subnormal vision problem

4. Strabismus, etc.

1. Patient unaware of disease

2. Patient aware but not under treatment

3. Consultation and confirmation

Is referral required?

1. Patient unaware of disease

2. Patient aware but not under treatment

3. Consultation and confirmation

Final Diagnosis - (Treatment)

1. Lenses and prisms

2. Orthoptics

3. Subnormal vision aids

4. Contact Lenses

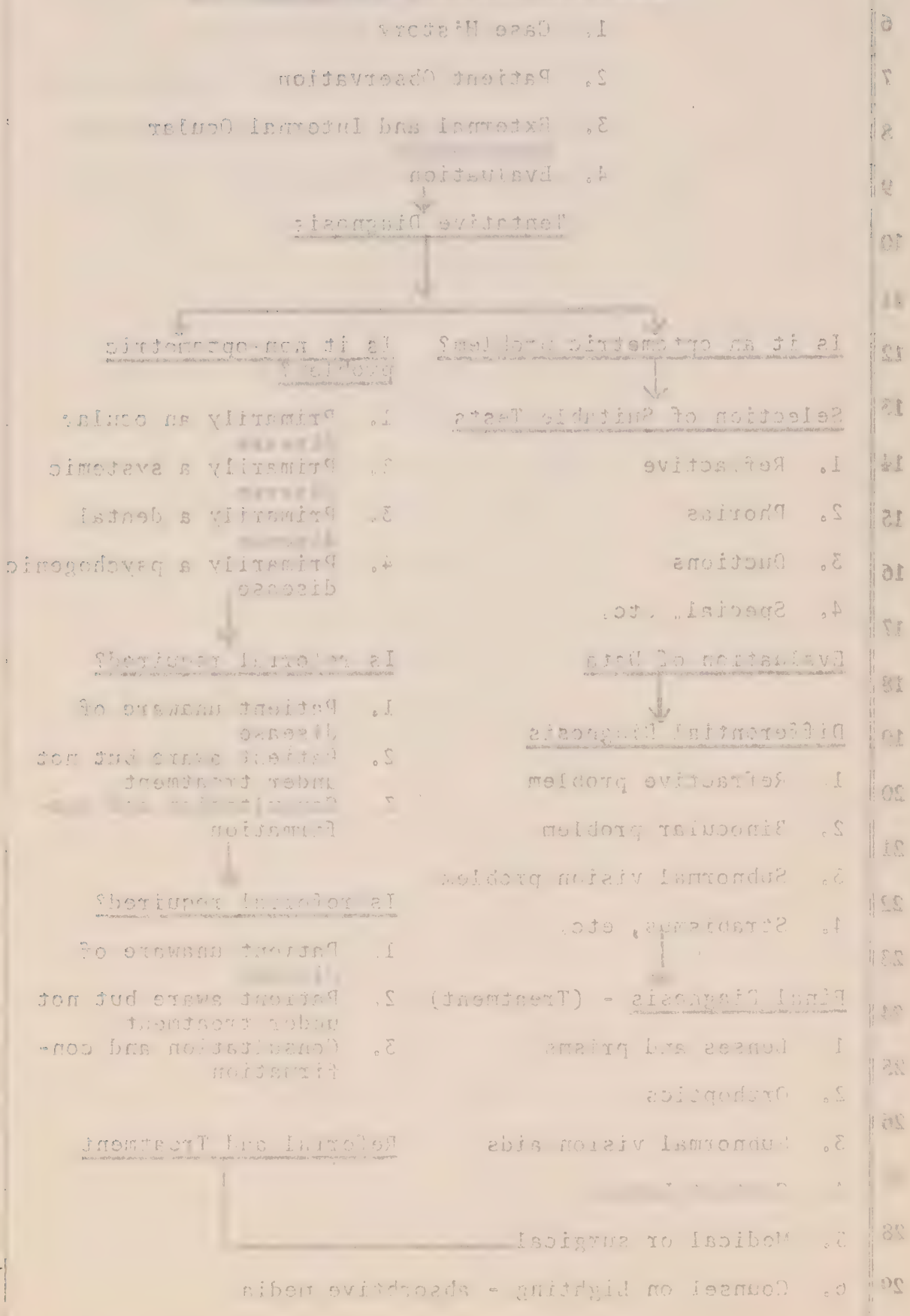
5. Medical or surgical

6. Counsel on Lighting - absorbtive media

Referral and Treatment



APPENDIX II





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We would thank you very much for your sincere work in this regard, and we reiterate that we stand ready to do all within our power to ensure that your deliberations and the results of your deliberations are transmitted into workable care for the Canadian people.

COMMISSIONER VAN WART: Does the Ontario Department of Health use the members of your Association in its visual programs?

MR. WOODRUFF: The Ontario Department of Health does not because of the way the administrative detail is set up. It is done by local units through county programs or city programs, and there again it is dependent upon the views of the administrator of the particular county or city program and, as a result, there is not a widespread use. There is some use, but it is not widespread.

COMMISSIONER STRACHAN: I want to know whether it is common practice for the Ontario Hospitals to have optometrists on their staff?

MR. WOODRUFF: No.

COMMISSIONER STRACHAN: Yours is an isolated case?

MR. WOODRUFF: I think mine is an isolated case. There may be some others that do some other work, but that is the only one to my knowledge.

COMMISSIONER STRACHAN: Does Workmen's Compensation recognize your Association?

MR. WOODRUFF: Yes. We have an excellent



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We would thank you very much for your sincere work in this regard, and we reiterate that we stand ready to do all within our power to ensure that your deliberations and the results of your deliberations are transmitted into suitable care for the Canadian

COMMISSIONER STACHAN: Does the Ontario Department of Health use the members of your Association in its various programs?

MR. WOODBURY: The Ontario Department of Health does not because of the way the administrative detail is set up. It is done by local units through county programs or city programs, and there again it is dependent upon the view of the administrator of the particular county or city program and as a result, there is not a widespread use. There is some use, but it is not widespread.

COMMISSIONER STACHAN: I want to know whether it is common practice for the Ontario Hospitals to have opthalmists on their staff?

MR. WOODBURY: No.

COMMISSIONER STACHAN: Yours is an

MR. WOODBURY: I think mine is an isolated case. There may be some others that do some other work, but that is the only one to my knowledge.

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MR. WOODBURY: Yes. We have an excellent



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relationship.

THE CHAIRMAN: Thank you very much,
gentlemen.

THE SECRETARY: Mr. Chairman, the
next submission is from the Canadian Association of
Optometrists Inc. Their brief will be R-10, and the
French version of that brief, which is a separate
document, will be R-10A, and Mr. Higgins will introduce
his group to the Commission.

---EXHIBIT NO. R-10: Supplementary submission
of The Canadian Association
of Optometrists Inc.

---EXHIBIT NO. R-10A: French version of brief.

THE CHAIRMAN: Thank you very much,

Gentlemen,

next submission is from the Canadian Association of

Optometrists Inc. Their paper will be P-16, and the

French version of that paper, which is a separate

document, will be P-101, and Mr. Higgins will introduce

his group to the Commission.

of The Canadian Association
of Optometrists Inc.

French version of paper.

EXHIBIT P-16



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SUBMISSION OF THE CANADIAN ASSOCIATION OF
OPTOMETRISTS INC.

APPEARANCES: E. B. Higgins
J. Vinson
H. Arnold
E.M. Finkleman
M. Belanger
D.R. Price

INTRODUCTION

This is a supplementary submission to the main brief submitted by the Canadian Association of Optometrists to the Royal Commission on Health Services in Toronto, Ontario, May 11, 1962. It is designed to elaborate on certain answers given the Commission at that time, to supply additional information, to re-emphasize some aspects of the original brief, and to comment on statements made in other briefs.

1. Recommendation No. 7 in the main C.A.O. brief states, "That a National Vision Bureau or Agency be created as a sub-committee of a National Health Services Planning Commission". Further reference to this recommendation occurs in paragraphs 55 and 95. Commissioner Firestone referred to these recommendations (see Pages 9669, 9670 - Transcript of Hearings). An elaboration of the answers given is herewith submitted.

2. The Canadian Association of Optometrists believes that a National Health Services Planning Commission should be established. This Commission could:



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(a) act as an intermediary between the three parties concerned in any health care plan, namely the public, the professions and the government.

(b) assure representation to these three parties in the planning, establishment and operation of any health care plan.

(c) provide a continuing committee for the purpose of studying new methods and ideas of health care, hearing complaints regarding modes of practise and procedures, and recommending to the appropriate agencies any changes deemed advisable. Essentially this would furnish a public forum where all parties concerned could express their views.

(d) form sub-committees, one of which would be concerned solely with eye care in all its aspects. This Association believes that such a committee is required because of the importance of vision in a health care plan, and also because there are two professions, optometry and ophthalmology, providing vision care.

3. A National Health Services Planning Commission need not supercede any existing agency, nor anticipate or override any recommendations of existing committees. It need not be an unwieldy organization numerically since many of its personnel would be members of existing organizations, and through regional sub-committees, a good deal of its work would arise from the local or grass roots level.

4. Recommendation No. 1 in the C.A.O. brief reads, "That a comprehensive Health Care plan be inaugurated to provide complete health services to the



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parties concerned in any health care plan, namely the public, the professions and the Government.

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Commission need not supersede any existing agency, nor

anticipate or override any recommendations of existing

committees. It need not be an entirely new organization

merely since many of its personnel would be members

of existing organizations, and through regional sub-

committees, a good deal of its work would arise from the

local or grass roots level.

Recommendation No. 1 in the C.A.O. Brief

reads, "That a comprehensive Health Care plan be in-

augmented to provide complete health services to the



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categories especially defined in Paragraphs No. 89 and 90". It is the opinion of the Canadian Association of Optometrists that all phases of eye care, viz: vision care and medical eye care, are integral parts of health care and should be included in any comprehensive general health plan. This Association believes further, that, while lack of vision care is not catastrophic nor its cost to the average individual prohibitive, it is nevertheless needed in a health care plan because of the high incidence of vision defects in the general population.

For certain age groups and an increasing number of occupations, the importance of adequate corrective procedures can scarcely be overestimated. Statistics supporting this belief are charted in Exhibits No. 17, 18 and 19 of the main brief. The subject is re-opened here to emphasize its importance.

5. Recommendation No. 5 asks, "that public health programs be enlarged to provide better vision screening of pre-school and school children". This subject was questioned by members of the Commission in more detail during the hearings of the Canadian Ophthalmological Society brief (see Pages 9720 to 9725 - official Transcript). The contention of optometry is that present screening methods are inadequate, and that optometrists and ophthalmologists are the only persons who are capable of providing adequate screening. Present day programs, with minor exceptions, do not make use of the services of either of these groups. The Orinda Study, reported by Blum, Peters, and Bettman, (Reference No. 10-Main Brief) and a joint optometrical-ophthalmological project carried



categories especially defined in Paragraphs No. 88 and 90. It is the opinion of the Canadian Association of Optometrists that all phases of eye care, vision care and medical eye care, are integral parts of health care and should be included in any comprehensive general health plan. While lack of vision care is not catastrophic for its cost to the average individual prohibitive, it is nevertheless needed in a health care plan because of the high incidence of vision defects in the general population.

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The correlation of optometry is that present screening methods are inadequate, and that of ophthalmologists are the only persons who are capable of providing adequate screening. Present day programs, with minor exceptions, do not make use of the services of either of these groups. The Canada Study, reported by

and a large number of other studies have shown that



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out in Hamilton, Ontario, are outstanding examples of the type of programs which should be instituted in all Canadian schools and pre-school clinics.

6. This Association wishes to re-emphasize recommendation No. 4, "That Colleges of Optometry and other teaching institutions be given adequate financial assistance". It is particularly important to realize that the College of Optometry of Ontario does not receive any financial aid or grants from any government. This subject was covered in Paragraph No. 50 of the main brief and in the opinion of the C.A.O. merits study and sympathetic consideration by members of the Royal Commission.

7. The submission made by the Canadian Ophthalmological Society contains the statement that "the only adequate eye care is medical eye care". It is difficult to assess the full meaning of this statement but if it infers that inadequate or inferior service is rendered by the optometrist then it ignores the facts. The facts are that optometry, along with other professions, has developed in an orderly and logical fashion during the past fifty years. It has constantly upgraded its educational standards, it has met new and demanding requirements placed on it by sociological charges, and it has made real progress in improving its standards of practise and ethical behaviour. These facts can readily be verified by a study of optometric curricula, programs of post graduate education, and present day modes of optometric practise under the laws, bylaws and codes of ethics governing such practise. Considering these evidences of progress, together with the support and recognition received from



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government agencies and the general public, this Association cannot accept such an inference. It does however recognize that full eye care must include medical eye care and has, as an Association, formally offered its cooperation to ophthalmology. It is still hoped that this offer will be accepted. In the meantime, charges, countercharges, recriminations, questionable statistics and heated statements do nothing to add to the quality and quantity of eye care.

8. The C.A.O. wishes to stress that optometry is a separate profession with special contributions to make in the field of eye care. Optometrists, with their numerical superiority and distribution, provide the major proportion of vision care in Canada. (See Table, Page-3, Optometry Exhibit No. 262). The same is true in Great Britain. (See Reference No. 11, Optometry, Exhibit No. 262). One vital service provided by optometry is the early referral of pathological conditions. The ability to perform this service was questioned in another brief. In answer to this, it should be emphasized that optometrists are trained to recognize, not diagnose, pathological conditions. In addition, the amount of pathology, its type, and the degree of referral are subjects which were thoroughly discussed and documented in Exhibit No. 262 (see Page 12-Optometry Brief). The evidence submitted indicates the competency of the present day optometrist in this area of practise. Apart from this service, the bulk of eye care concerns refraction and the prescribing and fitting of glasses. In this field optometry offers a single, unified service which is economical, convenient



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and easily administered. Optometry's role in a general health plan requires the utilization of all of these services in such a manner as to preserve the dignity, integrity and professional freedom of the individual optometrist. No one part of optometric practise should be segregated from the whole nor should any part be subjected to administration or domination by other professions or groups.

9. The Canadian Association of Optometrists is willing at all times to consider without prejudice any plan which will provide better health care and better eye care to the Canadian people.



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MR. HIGGINS: Mr. Chairman, Madam Girard, members of the Commission, my name is Edward Higgins. I am Managing Director of the Canadian Association of Optometrists. On my left is Jacques Vinson, a member of the Council, Canadian Association of Optometrists. On my immediate right is Harold Arnold of Saskatoon; on his right is E.M. Finkleman, president of the Canadian Association of Optometrists; M. Belanger, and D. R. Price of Gananoque.

I would ask Harold Arnold to present our summary to you.

MR. ARNOLD: Mr. Chairman, members of the Commission, we have spent a long morning, and it is not my intention to read this presentation; I assume you have all read it. I also believe this is the very, very last presentation you are going to hear. I imagine you would be very happy that it will be short and sweet.

THE CHAIRMAN: We are very happy to hear it, Mr. Arnold.

MR. ARNOLD: I think rather than read this I should lay stress on those things which we believe needed to be stressed, and I direct my first remarks to recommendations number one and number two to Dr. Firestone. The question was brought up at our last meeting in May, and the same question was discussed this morning when you examined very closely Mr. Andras. This concerns the setting up of a commission. At the time you asked us in May none of us was prepared to answer it, and I would ask you if you have any further questions you have in that regard.



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At the meeting of the Council, held

on the 11th of May, 1911, the following

Higgins, I am Managing Director of the Canadian

Association of Optometrists, on the 11th of May

Winnipeg, a member of the Council, Canadian Association of

Optometrists. On my immediate right is Harold Arnold

of Saskatoon; on his right is E.M. Finkelman, president

of the Canadian Association of Optometrists; M. Belanger,

and D. R. Price of Cananogue.

I would ask Harold Arnold to present

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you have in that regard.



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5 COMMISSIONER FIRESTONE: Mr. Chairman,
6 the answer is yes, I have a question.

7 First of all, I would like to congratulate
8 your Association for having come forward with some
9 concrete proposal. It is very, very helpful to the
10 Commission.

11 If I may have a little understanding
12 on how this National Health Services Planning Commission
13 which you are proposing would work. Do I understand you
14 have in mind a public or private institution?

15 MR. ARNOLD: Public.

16 COMMISSIONER FIRESTONE: And would a
17 government-sponsored, government-financed National
18 Health Services Planning Commission act as an inter-
19 mediary between the three parties in any health care
20 plan? How can a government appointed and government
21 financed commission act as intermediary between the
22 government and the public and professions?

23 MR. ARNOLD: Well, if you refer to
24 item (b), such a Commission would assure representation
25 on this commission of all the parties concerned, and
26 therefore if this was followed up the commission would
27 be composed of all the three parties, and therefore
28 the commission should function in the manner we have
29 envisaged.

30 MR. HIGGINS: I suggest another way
might be found in terms of the Board of Broadcast
Governors. The analogy, I think, is appropriate.

COMMISSIONER FIRESTONE: Now, this
commission would perform a planning function. It would



the answer is yes, I have a question.

First of all, I would like to congratulate your Association for having come forward with some concrete proposal. It is very, very helpful to the

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on how this National Health Services Planning Commission which you are proposing would work. Do I understand you have in mind a public or private institution?

Health Services Planning Commission act as an intermediary between the three parties in any health care plan? How can a government appointed and government financed commission act as intermediary between the government and the public and professions?

MR. ARNOLD: Well, if you refer to

item (b), such a Commission would assure representation on this commission of all the parties concerned, and therefore if this was followed up the commission would be composed of all the three parties, and therefore the commission should function in the manner we have envisaged.

MR. HIGGINS: I suggest another way

might be found in terms of the Board of Broadcast Governors. The analogy, I think, is appropriate.

commission would perform a planning function. It would



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also, presumably, perform an advisory function to government on matters concerning policies in the field of health care services. Is that correct?

MR. ARNOLD: That is correct.

COMMISSIONER FIRESTONE: What I would like to understand is, is this planning commission performing a planning function in the terms of doing the research, or do you visualize it to be an advisory commission or are you thinking of a commission like the Board of Broadcast Governors, which is really a regulatory commission?

MR. ARNOLD: First of all I will answer the last. We don't conceive or envisage this as being a regulatory commission in any shape or form. Secondly, I don't think it should be charged with actually running research programs, but it should be concerned with promoting them to the extent that they say they believe this area of research should be delved into; we suggest the government should do this, or whatever way it is worked out. These are administrative details.

MR. HIGGINS: I think we also have in mind, Dr. Firestone, that it would be catalytic in nature.

COMMISSIONER FIRESTONE: You are visualizing a forum, you bring all these people together who consider it in a studied manner?

MR. HIGGINS: Yes. In paragraph (c) it says "provide a continuing committee for the purpose of studying new methods and ideas of health care, hearing complaints regarding modes of practice and procedures,



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and recommending to the appropriate agencies any changes deemed advisable. Essentially this would furnish a public forum where all parties concerned could express their views." Optometry is very touchy about this because we are one of the smaller professions and one, you might take it from earlier submissions, that would have no say at all.

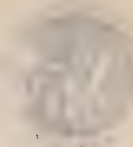
COMMISSIONER FIRESTONE: I take it this planning commission would be administered by government?

MR. ARNOLD: I would say basically on a federal basis and provincial basis and following below that the municipal level, and so on. They would never converse at this level. It is no different than our national organization. We have local groups in cities and communities, and suggestions come up to the provincial level and then up to the national level and it comes to the delegates. They never all come together.

MR. BELANGER: This is the system, as I understand it, in England. Although there is a national body and local councils, they are divided on a county basis, I think 23 for England; I am not sure of the number. I think this is the idea that Mr. Arnold has brought forward.

Secondly, I think we should not confuse this planning commission with an administrative body set up to administer. We think that this should be a policy-making organization and which would lay down the rules.

COMMISSIONER FIRESTONE: If I understand you correctly, sir, this national health services planning



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COMMISSIONER FIRSTON: If I understand



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commission is an advisory body on policy questions; is that correct?

MR. BELANGER: That is my interpretation.

THE CHAIRMAN: In England, my understanding is that the council, the regional council, is an administrative body, actually operates the plan in the area.

MR. ARNOLD: This is true. The so-called Whitely Councils are regulatory bodies. We don't envisage this at all.

COMMISSIONER FIRESTONE: But we are just trying to understand what your proposal is, and, as I understand it, you are visualizing a national health services planning commission which has an advisory function and it would be separate from whatever administrative bodies are set up.

MR. ARNOLD: Yes. It may then develop on a decentralized basis; it may have sub-committees at different levels.

COMMISSIONER FIRESTONE: But that is the general objective?

MR. ARNOLD: Yes, this is the overall plan.

COMMISSIONER FIRESTONE: Assuming we had such a commission, what would this commission try to do, what kind of planning would it do, what kind of advice do you think it might give?

MR. ARNOLD: Initially, and I am not trying to here interpret for the Commission what they may recommend or may not recommend, I would think this



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5 commission would follow the recommendations that you
6 people here are ultimately are going to make or supposed
7 to be going to make. This is how we envisage it. This
8 Commission here would be charged with the carrying out
9 of those ideas and directives and recommendations which
10 have come from the health services planning commission.
11 Following this, this national health services planning
12 commission would be the public form again through which
13 all the existing parties, not just the professions but
14 the public or, as Mr. Andras called them, the seller
15 of the service and the consumer, would all be represented,
16 and the commission would operate with the minimum of
17 friction and the highest level of accomplishment.

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COMMISSIONER FIRESTONE: Let us assume
for the moment that on this commission these three
broad groups are represented. There may be many more.

MR. ARNOLD: Yes.

COMMISSIONER FIRESTONE: Let us say
some of the groups represented differ in their views
to the views expressed by the consumer interests, and
then the government representatives sit on the fence.
What kind of proposals would come out of this?

MR. ARNOLD: It is obvious if this
came to pass and there were no resolutions made, then
an impasse would be reached. I would think that men
of goodwill would resolve any difficulties and not come
up with any impasse.

COMMISSIONER FIRESTONE: And you think
that having made recommendations it would facilitate the
development of these plans and whatever was required in

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these plans?

MR. ARNOLD: Yes, that is correct.

COMMISSIONER FIRESTONE: That is very helpful. Thank you very much.

THE CHAIRMAN: Doctor Baltzan?

COMMISSIONER BALTZAN: Mr. Chairman, I cannot just now see any questions.

MR. HIGGINS: Mr. Chairman, I wonder if I may comment very briefly on a statement made by Dr. Wodehouse yesterday.

Dr. Wodehouse was quite clear yesterday in his definition of the word "comprehensive", that it included only medical care. I would respectfully draw your attention to the terms of reference of this commission that the phrase "health care" has been used, and particularly ask that you bear in mind that at least as far as we are concerned, when we use the words "comprehensive health care", that this is not solely within the field of medicine but encompasses the legitimate licensed services of other groups who are active in rendering care to the people of Canada in their respective areas. There is a very strong distinction that can be made there.

THE CHAIRMAN: Well, Mr. Higgins, if you were listening this morning, and I think you were, I put that proposition to Mr. Andras, the idea that physicians' services were paid for, that you would then be in seventh heaven. You were just expressing what I was thinking at that time.

MR. HIGGINS: That is correct. Mr. Andras



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Angus

COMMISSIONER FINCHAM: That is very

helpful. Thank you very much.

THE CHAIRMAN: Doctor Fincham

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MR. HIGGINS: Mr. Chairman, I wonder

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MR. HIGGINS: That is correct. Mr. Angus



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was quite clear when he referred to other members of the health care professions. While the basic medical care is important, we would say that there are other areas which are perhaps equally important, and I would say that one of the functions of this advisory planning commission that we would recommend would be to give reasonable consideration to the order of priorities of services and, secondly, to provide a badly-needed catalytic function. I don't think I need have to draw to the attention of your Commission that there are serious inter-professional relationship problems which must be resolved in the public interest.

MR. FINKLEMAN: I think, Mr. Chairman, you asked a question previously with regard to the services rendered in rural areas. I come from Winnipeg, and we have rather a unique situation in Manitoba in which there is a concentration in the City of Winnipeg of 50% of the optometrists in Manitoba and 95% of the ophthalmologists, let us say. Practically all the ophthalmologists are in the City of Winnipeg, with the exception of one or two in Brandon; the others are situated in the larger towns and cities in Manitoba. Optometrists do cover rural areas on a very definite schedule, and the Manitoba Report indicated that practically every sizable community in Manitoba had optometric services available to them on a reasonably frequent basis.

This carries out the level of practice equivalent to the type of work available in the original office, or in the main office

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MR. WINSTON: I think, Mr. Chairman,

you asked a question previously with regard to the services rendered in rural areas. I come from Winnipeg and we have rather a unique situation in Manitoba in which there is a concentration in the City of Winnipeg of 50% of the optometrists in Manitoba and 85% of the ophthalmologists, let us say. Practically all the ophthalmologists are in the City of Winnipeg, with the exception of one or two in Brandon; the others are situated in the larger towns and cities in Manitoba. Optometrists do cover rural areas on a very definite schedule, and the Manitoba report indicated that practically every sizable community in Manitoba had optometric services available to them on a reasonably frequent basis.

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of the optometrist. We are very particular about that. I myself do this type of work because ours happens to be a large office, with my brother and father.

In two towns where we have clinics, we work right in the local hospital and we enjoy a very fine relationship with the medical doctors who also have offices in these rural hospitals.

Other optometrists in Manitoba who do work in the rural areas, if facilities in hospitals are available in the town, usually utilize those facilities, utilize the central area of the hospital for their practice, and I draw this to your attention particularly to emphasize the rather good relationship that exists between optometrists and general medical practitioners in this particular field and the manner in which this type of work is continuing.

THE CHAIRMAN: Is there any reason why this type of work could not flourish in other parts of Canada? Rural areas of Canada?

MR. FINKLEMAN: I think the reason is there is, shall I say, a certain stigma from years gone by when there was the itinerant eye-glass peddler, if you want to go back a good many years.

THE CHAIRMAN: When I referred to itinerant there, I was not referring to anybody except the mobile clinics.

MR. FINKLEMAN: This had a very rather poor connotation at one time. As pointed out previously, it is economically impossible for an optometrist to establish an office in some of the very small towns that



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MR. FINKLEMAN: This had a very rather



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exist in some of the Prairie Provinces, particularly and when those services are needed, an optometrist within say 50 or 100 miles of that town will render that service on exactly the same basis as it might be done in his own office, except for the elegance of surroundings, in some cases.

MR. HIGGINS: Page 7 in the original brief submitted by the Canadian Association of Optometrists there is a full page there discussing what goes on in each Province in this connection, sir.

COMMISSIONER VAN WART: Would there be figures for this type of service?

MR. ARNOLD: In the Nipowan, Star City area, different areas, we now have a resident optometrist and immediately the demand doubles, there is a resident in one of these towns. This means it is no longer economically feasible or even ethical for a man to go in there on a travelling basis. This has happened in Nipowan, Star City, a number of towns now have established resident optometrists, so that a travelling optometrist no longer is of necessity.

THE CHAIRMAN: Does this indicate, Mr. Arnold, there was a shortage? You seem to be getting enough optometrists to fill these areas?

MR. ARNOLD: These are the post-war graduates. They are the graduates who became opticians, 130 graduates a year in the first two or three years after the war.

THE CHAIRMAN: From what school?



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MR. VAN WAT: These are the post-war

graduates. They are the graduates who became opticians,

130 graduates a year in the first two or three years

after the war.

From what schools?



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MR. ARNOLD: Mostly from the Toronto School.

THE CHAIRMAN: If you were able to graduate 130 in the war, why cannot you do it today, if the necessity exists?

MR. BELANGER: At that time it was only possible to do so because the University of Toronto made available to us a good deal of tuition in the basic sciences, as well as the physical facilities for classrooms and laboratories and our own facilities, which are being used now, would not permit that type of thing.

THE CHAIRMAN: Why were these facilities withdrawn, or did you withdraw them?

MR. BELANGER: Might I just add there were also grants from the Department of Veterans Affairs to the College which made it financially possible to have a staff at the College to meet the needs of these members. There has been a gradual evolution of the College to provide an integrated educational program. Previously, the University of Toronto did provide tuition in basic sciences such as physiology and psychology, and so on. I think perhaps the Dean might answer more specifically about the conditions.

THE CHAIRMAN: Arising from what you have said this is perhaps an important question: Does your College want to give that instruction yourselves or would you be satisfied to have that done by the University, leaving to the College the instructional work on the training in the specific aspects of optometry, as distinct from the basic sciences?



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MR. LANGER: Most assuredly we would be quite pleased to have that instruction provided at the University and this would, of course, alter our requirements in terms of physical facilities, considerably.

MR. BELANGER: That was a situation which existed when I graduated in 1945, that all basic sciences were taught at the university. Also took psychology, anatomy in the medical school, by the way, by Dr. Cates.

THE CHAIRMAN: Why were they discontinued?

MR. BELANGER: That is the problem. I cannot give any answer. There is one thing that I have understood to be one of the factors, with the ever increasing demand for their own students they decided to do away with the group attending as occasional students.

We were occasional students only and seeing that they had enough students of their own, or too many of their own, they had to do something and, of course, being occasional students we had to be let out. This is my interpretation. It may not be the right one, but it is my interpretation.

MR. FISHER: One of the reasons the University gave for discontinuing such instruction was the fact that it could not handle occasional students in the future due to the large influx that was anticipated, and which they were experiencing in these days, and, as a result, they indicated that they could not continue to provide this instruction for any outside groups.

MR. PRICE: I do not wish to change the



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subject. I will be changing the subject but I do not want to change it until it is time.

THE CHAIRMAN: You go ahead. Now is a good time.

MR. PRICE: This is almost in the way of a very short summary, but one word of caution: I feel that the optometric presentations have sufficiently left the impression that there is more reason for our justification in being here, rather than just our numbers. We have standards of training, and so on, that qualify us, without question, to be in the vision care field.

We also recognize the fact a comprehensive health care scheme is likely to be brought in in stages. This seems to be the logical course of events and there is one concern which optometry has and that is simply this: If these stages are so geared that refraction benefit, as normally described, is left out, that will exclude optometrists obviously from any particular plan that is envisaged but it will not include the ophthalmologist, as such, because as has been explained by them they consider, or at least they have said they consider that the refraction is not an entity in itself. It is part of a medical examination, so that in this sense it would be, we feel, almost impossible to exclude refractions and yet still include medical benefits.

Now this is a concern of optometrists, but it is a concern for the role we can play.

THE CHAIRMAN: Mr. Arnold, can you offer any light on why refractions by optometrists were not covered under the Saskatchewan Medical Care Insurance

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Act? Were representations made that they should be included?

MR. ARNOLD: Yes. We recommended that if there was a comprehensive health care plan that optometrists should be included. That infractions both by ophthalmologists and optometrists should be provided.

I think the only reason why the Government have left that out and left dentistry out, and any of the others is simply a matter of finances. They have said quite clearly that when the time comes that refractions, and the provisions of glasses, and dentistry and any of the other paramedical courses you think of will be included.

THE CHAIRMAN: What do you mean "when the time comes"?

MR. ARNOLD: When they feel that they can finance it, I assume.

MR. HIGGINS: Mr. Chairman, I wonder if I might pick up where Mr. Price was speaking about the officially stated attitude of the medical profession that a refraction is part of a complete medical examination. I would draw your attention to a very apparent discrepancy in this statement in that, according to their own official document published by Physicians Services Incorporated, owned and operated by the Ontario Medical Association, that under sub-section 3, available services, they list twelve additional services that are available and one of these, and I quote from sub-paragraph 10 "Refractions, that is testing for eye glasses, when done by a participating specialist physician". It would,



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therefore, appear that a refraction benefit is a separate and distinct service and that according to the medical records themselves that not less than 4% of the population have a vision problem which involves pathology. The other 96% involves problems allied within the specialty field of the optometrist and deal with the problems of the eye, which are non-medical in nature.

THE CHAIRMAN: I am not going to purport to speak for my medical confreres. I suppose this is a question which is outside our ambit. There are some 1,200 practising optometrists in Canada and this makes the problem one that we must give consideration to, regardless of the question of whether it is a medical or non-medical problem, or whatever else it may be. We have to face up to reality, and when you say 60% of the people in Canada with regard to refractions are being taken care of by optometrists, well we cannot miss you no matter how thick the woods might be.

MR. ARNOLD: I would think it is very largely an administrative problem rather than one of actual planning in the sense that the people are going to plan the actual administrative details.

At the outset I said there were three things I wanted to speak about. I mentioned two. I will mention the third and say no more.

The third factor I want to bring up is covered on page 2 of our submission, paragraph 7, and it deals essentially with the relationship which exists between ophthalmology and medicine, on the one hand, and optometry on the other. I do not think that this is

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a subject which should really be discussed completely openly in a gathering like this. I do not think this is the purpose of the Commission.

THE CHAIRMAN: That is what I just said. I do not think we are organized to resolve that problem.

MR. ARNOLD: I think this problem is best resolved between the professions quietly, and I am glad to say that there is evidence now occurring of at least a little bit of the opening of the door in these relationships.

We hope to accomplish something. I did want to bring up an answer to one question asked about the College of Optometry at the University of Montreal, whether or not there was an ophthalmologist on staff there. It is my understanding that there was and that he had been withdrawn.

MR. VINSON: There was a teacher in ophthalmology at the School of Optometry at the University of Montreal and he was prohibited from teaching and the Board of the School has to hire an ophthalmologist from Boston who flies weekly into Montreal to give lectures in ophthalmology.

COMMISSIONER BALTZAN: Was this action on the part of the University? Was this withdrawal made on the part of the University or a particular faculty of the University?

MR. VINSON: This seemed to be from the resolution adopted by the College of Physicians of the Province of Quebec where they forbid their practitioners to teach optometry.

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COMMISSIONER BARTON: Was this action

on the part of the University? Was this withdrawal

made on the part of the University or a particular

faculty of the University?

MR. WILSON: This seemed to be from the

resolution adopted by the College of Physicians of the
City of Quebec where they forbid their practitioners
to teach ophthalmology.



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COMMISSIONER BALTZAN: That is not necessarily with the consent of the University body?

MR. VINSON: I believe that this stems from their internal policies of the College of Physicians to prevent their members teaching optometry.

MR. BELANGER: At that particular time the Dean of the School phoned me personally in Ottawa with the hope I could obtain the services of two ophthalmologists who were doing research at the University of Ottawa in the hope they would go down weekly to the University of Montreal and teach there.

The reason for this situation was that the doctor who had been teaching ophthalmology had been threatened with closure of hospital facilities if he continued. In other words, what ophthalmologist can practise ophthalmology if he has no hospital facilities?

This was a telephone conversation and I am sure the Dean of the School can substantiate it with me. This occurred several years ago but the ophthalmologist here could not get away from his research assignment. That is when they had to go across the border.

THE CHAIRMAN: You will appreciate, gentlemen, that there are some problems that this Commission will not be able to solve.

MR. ARNOLD: Just leave it to us, sir.

THE CHAIRMAN: I want to thank you. I hope you gathered from the interest that the Commission has shown in the questioning, and in the listening to your presentations, that your problem and those of the



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other paramedical professions are problems we are going to have to pay considerable attention to. Your presence here, and the former submissions you have made have given us the information and background from which we will be able to at least try to see what ought to be recommended. Thank you very much.

MR. FINKLEMAN: May I be permitted to read a final statement?

It seems only fitting that since we are the last organization to appear before your Commission, we should acknowledge on behalf of our profession and indeed all of the people of Canada, the debt of gratitude due to members of the Royal Commission on Health Services. We recognize the magnitude of the task now before you in studying, correlating and preparing your final report and recommendations.

May we also take this opportunity of impressing on you the sincerity of our presentation. We express our earnest desire to serve in these plans of social change and to stress again the importance of optometry's field of service in any comprehensive health care plan, as a separate and distinct member of the health care professions.

As specialists in the field of vision care, who today provide by far the greater percentage of vision care to the people of Canada, we again reiterate our willingness to continue to provide such care. We also emphasize our desire to co-operate with any or all professions in the health care field in order that the people of Canada may receive those standards of health care



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which they require. Optometry has a contribution to make in the health care field and this responsibility it accepts and will continue to accept.

Thank you very much. We wish you well.

THE CHAIRMAN: Thank you very much, Mr. Finkleman. We are very grateful to you for your very nice words.

I am in the position that many a judge often is. After hearing the argument everybody is his friend but when judgment comes out, he is not so good. We hope that you still have the same opinion after the report.

THE SECRETARY: Dr. Sutherland of the Canadian Chiropractic Association would like to make an additional statement.

DR. SUTHERLAND: Mr. Chairman, members of the Commission, it is certainly not my desire, or my intention to prolong this session any longer than necessary, and I am most appreciative of this opportunity to take perhaps five or ten minutes to clarify one or two points which were raised yesterday.

One point was in regard to the submission made by the Canadian Medical Association and one with regard to the question raised during our own presentation.

The first point I would like to comment on is with regard to the availability of x-ray reports and films to chiropractors. If I might be permitted to give a word or two of background information on this topic, first of all, the use of x-ray equipment by chiropractors is a most necessary adjunct in determining

which they require. Generally, a contribution to make in the health care field and this responsibility it accepts and will continue to accept.

Thank you very much. We wish you well.

THE CHAIRMAN: Thank you very much.

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the need of the patient for treatment, and the type of manipulation to be provided so that it is most necessary we have access to x-ray reports.

THE CHAIRMAN: You mean, Dr. Sutherland, all x-ray reports of any patient, or x-ray reports that are requisitioned for examination, that are requisitioned by chiropractors?

DR. SUTHERLAND: I am only speaking of x-ray reports affecting patients who have come to a chiropractor for treatment and have had x-rays taken by some other laboratory, or other hospital or radiologist.

THE CHAIRMAN: In respect to the same condition?

DR. SUTHERLAND: Yes. That might become clear as I go through these points.

(2) D.C.'s training in x-ray field is 184 hours plus to give him the understanding of spinal mechanics and pathology that enable him to care for the patient effectively and to recognize when pathology is present which would contra-indicate spinal manipulation and require the case to be referred to a specialist in another field.

This is training of all graduates, however, some choose to extend this by taking post-graduate work through the Canadian Council of Chiropractic Roentgenology, an affiliate of the Canadian Chiropractic Association.

(3) This training is greater than that demanded of a general practitioner and in x-ray, but not as great as for a radiologist.



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This fact is recognized by Workmen's Compensation Board of Ontario which pays the same fees for x-ray services to chiropractors as to general practitioners of medicine. This amounts to 75% of the fee paid to radiologists.

C.M.A. spokesman remarked that the services of a radiologist are not always required in the field of Roentgenology and this is quite true although films showing development of pathology should certainly be referred to them for expert opinion.

There are two aspects to this problem:
(1) Reports on pathology present in regard to the patient's condition which might affect his treatment or cause him to refer the patient to someone and they should receive a copy of the radiologist's report simply stating what he has found.

Secondly there is the added factor of the possibility of studying films for spinal mechanics, in which he is well trained.

Such co-operation would help to eliminate extra radiation being experienced by the patient and would avoid the added expense of additional films.

In practice these reports and films are not provided, with a few exceptions.

THE CHAIRMAN: Even if the patient directs that that be done?

DR. SUTHERLAND: Yes. This has happened sir. There are a few notable exceptions. I have personally entered several hospitals to review films. On one occasion, when I identified myself, and it was a



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4 Compensation Board film which had been taken in the
5 hospital, I was told that their policy did not permit
6 them to allow me to see this film, even though I was
7 treating the patient at that time for the Compensation
8 Board.

9 I had to phone the Board from the
10 hospital and request that they suggest to the radiologist
11 that I might be allowed to see it and then rather
12 reluctantly it did take place.

13 This is quite a problem. One of our
14 delegates had a letter from the Medico-Legal Adviser
15 to the Ontario Hospital Services Commission stating that
16 the responsibility for releasing his films rests with
17 the governing board of each hospital. And they can
18 enforce the policy of not releasing information quite
19 strictly.

20 Now this works a hardship on the
21 patient and the chiropractor and it becomes a very
22 confusing state of affairs and people say why don't you
23 professions co-operate better than this? The patient
24 is quite annoyed on occasion and he actually demands his
25 film, and of course this causes a problem between his
26 medical practitioner and himself which is unsatisfactory.

27 We feel that correction of the problem
28 would not present any added expense, and, in fact, would
29 reduce the cost of services in many instances.

30 The second point has to do with the
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science in the university, medicine would have no quarrel with them and they could become good orthopaedic surgeons.

Now, I submit that this is equivalent to saying that we have no quarrel with chiropractors as long as they stop being chiropractors.

THE CHAIRMAN: You do not have to make a formal presentation in response to a statement like that.

DR. SUTHERLAND: Fine thank you sir. There was a similar statement made by the American Medical Association regarding osteopaths which stated that they could be accepted by medicine if they rejected their premise and became physicians.

Both statements assume that our present basis is unsound and that we should be encouraged to enter other fields.

This is the very point we endeavoured to make yesterday -- that any form of affiliation must not interfere with the development of our profession, based on its present concept of faulty spinal mechanics as a cause of many conditions.

This is a true foundation based on known facts of anatomy and physiology, and in order for any form of affiliation to work successfully will be necessary for medicine to state that our concept is correct and that our members are providing a useful and needed service to the sick. Until such a level of understanding is reached, then any suggestion of affiliation is not practical. However, as mentioned in



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our original submission, we are conducting a study of this problem currently.

In our original brief we have presented ample evidence from medical and chiropractic authorities substantiating the sound basis for our works. This indicates that medicine should re-appraise its position regarding spinal manipulation therapy and recognize the value of the work being done by the duly licensed qualified chiropractor. In fact, such a re-appraisal was recommended to them in their journal, the Canadian Medical Association's journal, in an article about chiropractors and appears in our original submission as Appendix 3.

I might mention that in Quebec affiliation was recommended in that province when we applied for recognition. It was suggested to the premier that we should approach the authorities with a view to having a chiropractic course in the university, but the medical approach to the universities resulted in them rejecting this recommendation in 1961, and no progress has been made in that connection. I was also informed recently that the College of Physicians and Surgeons is collecting information with regard to chiropractic in the United States. For what reason we don't know, but information is being collected.

In Nova Scotia the suggestion was made by the government that medicine and chiropractic co-operate in drafting suitable legislation, but although we were willing, no such co-operation developed. Under these circumstances it is difficult for us to see how



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affiliation with a university would be practical at the present time.

However, as our course is already at university level, we are not averse to negotiating with respect to university affiliation for teaching basic science subjects, but this can only be accomplished in the proper climate, where there is no antagonism, and where the foundation of our work is granted the recognition it deserves, being based on sound physiological facts.

That is the conclusion of my written statement, Mr. Chairman.

Might I have permission to make three brief reference to publications which have come to our attention?

THE CHAIRMAN: Yes.

DR. SUTHERLAND: This is an article from the University of Toronto Medical Journal, and this again is with regard to affiliation and the climate in which this would occur. The medical students at the University of Toronto wrote to our College in the following words:

"In the course of our education in the
"Faculty of Medicine we have discovered
"that both students and practitioners
"were unfamiliar with this field of
"chiropractic. We have found that the
"general view of the faculty concerning
"your field, akin to the medical
"profession, was that chiropractic



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"represented a cult rather than a
"science, and the editorial staff of
"our journal feels it is unfortunate
"that this opinion continues being
"inculcated into the undergraduate body.

"We believe that a considerable
"proportion of this prejudice is due to
"lack of knowledge concerning the
"position of the chiropractor in the
"science of healing and rather than
"admit this fact the physician tends to
"demerit the profession in the face
"of questioning by interested students."

And they go on to say that to counteract this bias they
would write an article as to an understanding of our
work.

I will skip the second reference to
save time.

What really brought our thinking to a
head in this matter was an item in a textbook entitled
"Health Values For Use In High Schools." The Medical
Association has embarked on a nation-wide campaign to
oppose chiropractic practice. This article states:
"Scientific medicine....(reads)." We have refuted that
stand in our original brief, that medical investigations
have, indeed, substantiated that misaligned vertebrae
do occur, and, indeed, there are references to this in
medical literature to this effect.

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critical of the situation; we want to help to create a proper atmosphere in which proper co-operation can be developed, and we assure you of our co-operation and thank you for allowing us to make this brief statement.

THE CHAIRMAN: Thank you, Dr. Sutherland.

Gentlemen, that concludes our rebuttal hearings and it finishes the Commission's public hearings.

We will now adjourn and meet again in the Daley Building at three o'clock, where we will continue our deliberations in private.
